**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345279
- **(X2) MULTIPLE CONSTRUCTION**
  - A. BUILDING ________________
  - B. WING ________________
- **(X3) DATE SURVEY COMPLETED:**
  - C
  - 05/02/2017

**NAME OF PROVIDER OR SUPPLIER**

- **HUNTER HILLS NURSING AND REHABILITATION CENTER**
- **STREET ADDRESS, CITY, STATE, ZIP CODE:**
  - POST OFFICE BOX 8495
  - ROCKY MOUNT, NC 27804

**SUMMARY STATEMENT OF DEFICIENCIES**

- **(X4) ID PREFIX TAG**
  - F 000
  - INITIAL COMMENTS
  - There were no deficiencies cited for Event # 3GDZ11.
  - F 000

**PROVIDER'S PLAN OF CORRECTION**

- **(X5) COMPLETION DATE**
  - ELECTRONICALLY SIGNED

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Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.