## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<td>345417</td>
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**Date Survey Completed:**

R-C

06/08/2018

**Name of Provider or Supplier:**

HILLSIDE NURSING CENTER OF WAK

**Address:**

968 EAST WAIT AVENUE

WAKE FOREST, NC 27588

**Summary Statement of Deficiencies**

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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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**Initial Comments:**

A paper revisit was conducted on 6/8/18. The facility is in compliance as of 5/30/18.

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

Electronically Signed

06/08/2018

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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.