STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________

B. WING _____________________________

C. MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER

HUNTER HILLS NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

7369 HUNTER HILL ROAD

ROCKY MOUNT, NC  27804

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of complaint investigation Event NDJ11.

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.