**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345279
- **(X2) MULTIPLE CONSTRUCTION**
  - **B. WING _____________________________**
- **(X3) DATE SURVEY COMPLETED:** C 08/06/2020

**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

**FORM APPROVED:**
- **DATE:** 08/06/2020
- **345279**

**ID** | **PREFIX** | **TAG** | **ID** | **PREFIX** | **TAG**
---|---|---|---|---|---
F 000 | INITIAL COMMENTS | F 000 | A Complaint investigation was conducted 8/5/2020 through 8/6/2020. Event ID# SPYJ11. 11 of the 11 complaint allegation(s) were not substantiated.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**DATE:** 08/11/2020 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.