STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 07/10/2014

NAME OF PROVIDER OR SUPPLIER
DURHAM NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
411 S LASALLE STREET
DURHAM, NC  27705

PART I: SUMMARY STATEMENT OF DEFICIENCIES

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<td>INITIAL COMMENTS</td>
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No deficiencies were cited as a result of this complaint investigation survey, Event KJDU11.

PART II: PROVIDER’S PLAN OF CORRECTION

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE
Electronically Signed 07/24/2014

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.