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 02/04/2019

NAME OF PROVIDER OR SUPPLIER
DURHAM NURSING & REHABILITATION CENTER

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

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies were cited as a result for the
complaint investigation Event ID # C0VN11.

F 000

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

Electronically Signed

02/06/2019

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.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: C0VN11 Facility ID: 923264
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