### Statement of Deficiencies and Plan of Correction

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

- A. Building ____________________________
- B. Wing ___________________________

**Name of Provider or Supplier:**

HILLCREST CONVALESCENT CENTER

**Street Address, City, State, Zip Code:**

1417 W PETTIGREW STREET
DURHAM, NC  27705

---

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complaint Investigation survey conducted from 12/09/20 through 12/09/20. Event ID# PRZQ11 1 of the 1 complaint allegation was not substantiated.

---

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.

---

Electronically Signed: 12/31/2020

---

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

Electronically Signed

12/31/2020