**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING______________________**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345061

**STATEMENT OF DEFICIENCIES**

- **DATE SURVEY COMPLETED:** 01/06/2021

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An onsite follow-up investigation was conducted on 01/06/20. The facility was found to be back in compliance effective on 12/16/20.

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

**NAME OF PROVIDER OR SUPPLIER**

PRUITT HEALTH-DURHAM

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3100 ERWIN ROAD
DURHAM, NC 27705

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

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.