**Statement of Deficiencies and Plan of Correction**

**Date Survey Completed:** 05/25/2021

**Provider/Supplier/CLIA Identification Number:** 345070

**Name of Provider or Supplier:** DURHAM NURSING & REHABILITATION CENTER

**Street Address, City, State, Zip Code:** 411 S LASALLE STREET DURHAM, NC 27705

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### Summary Statement of Deficiencies

**ID** | **Prefix** | **Tag** | **Remarks**
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F 000 | INITIAL COMMENTS | F 000 | An unannounced complaint investigation was conducted onsite on 05/25/2021. Event ID #DJLE11. 8 of 8 complaint allegations were not substantiated.

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

**Title:**

**Date:** 05/27/2021

Electronically Signed

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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.