STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durham Nursing & Rehabilitation Center	411 S Lasalle Street Durham, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident, family member, and staff interviews, the facility failed to honor a resident's choice related to shower time for 1 of 5 residents reviewed for choices (Resident #53). Findings include:Resident #53 was admitted to the facility on [DATE] with diagnoses that included contractures of right hand, left and right knees, and chronic kidney disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #53's cognition was intact. He had a range of motion impairment on both sides of his lower extremities and utilized an electric wheelchair for mobility. Resident #53 was dependent on staff with toilet hygiene, shower/baths, dressing, personal hygiene, bed mobility, and transfers. Resident #53 had an external catheter and was always incontinent with bowels. Resident #53 was not coded for rejection of care during the look back period.A review of Resident #53's active care plan, last revised 03/20/26, included a focus area for activities of daily living (ADL) self-care performance deficit related to spastic diplegic cerebral palsy.A review of the Shower Schedule located in a binder at the nurse's station was conducted. The shower schedule had a list that included the room number and shift the shower was to be given on. The schedule revealed Resident #53 was to receive a shower every Tuesday and Thursday on second shift (3:00 PM to 11:00 PM).An interview was conducted on 04/13/26 at 2:14 PM with Resident #53. He reported that a new company purchased the facility in December 2025, and in January 2026 his shower times were changed from 7:00 AM to 3:00 PM (1st shift) to 3:00 PM to11:00 PM (2nd shift). He stated he had always received his showers on Tuesdays and Thursdays during 1st shift. Resident #53 explained that no one informed him that his shower times would be changed, nor did anyone ask whether he wanted to change his established schedule. He stated that when he learned of the change (he did not recall who notified him), he informed several staff members on multiple occasions that he did not want his showers on 2nd shift and wanted his original 1st shift schedule restored. He reported being told by several staff that the schedule could not be changed. Resident #53 stated that his family visited approximately three weeks ago. He told them the facility would not change his shower times back to 1st shift, and his family then requested to speak with the Director of Nursing (DON). According to Resident #53, the DON told him and his family she would look into the matter and see what could be done. He reported that he had not received any followˆup in almost three weeks. Resident #53 stated that the situation had been frustrating and that he simply wanted his request honored, as he believed it was his right.An interview was conducted on 04/15/26 at 9:23 AM with Nurse #9. She stated that Resident #53 was dependent on staff for his activities of daily living. Nurse #9 explained that Resident #53's showers had previously been scheduled for Tuesdays and Thursdays during 1st shift (7:00 AM to 3:00 PM), but the new owners changed his shower times to 2nd shift (3:00 PM to 11:00 PM). She reported that Resident #53 became upset when he learned of the change and expressed that he wanted his shower schedule returned to 1st shift. Nurse #9 stated this issue had been ongoing since January and that Resident #53's preferences had been communicated to the administrative staff. Nurse #9 did not know why the change had occurred.An interview was conducted on 04/15/26 at 9:31 AM with Nursing Aide (NA) #2. She stated that she was very familiar with (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 and was assigned to his hall on the days she worked. NA #2 reported that the new Director of Nursing (DON) changed Resident #53's shower schedule in January from every Tuesday and Thursday on 1st shift (7:00 AM to 3:00 PM) to 2nd shift (3:00 PM to 11:00 PM). She stated that Resident #53 had been requesting to have his showers changed back to 1st shift since the change occurred. NA #2 explained that Resident #53 had always received his showers during 1st shift. She also stated that she had been informed by the DON the time could not be changed.An interview was conducted on 04/15/26 at 10:02 AM with Unit Manager (UM) #1. She verified she started working at the facility in December 2025 when the new owners started at the facility. The UM explained in January 2026 the Director of Nursing (DON) had initiated a new shower schedule for the staff to follow. UM #1 stated she had been the UM on Resident #53's hall for approximately 2 to 3 weeks when the DON asked her to re-evaluate the shower schedule assignments for the entire building to see if any residents had day or time preferences due to concerns that had been brought to the DON. UM #1 indicated the DON explained that some residents were alert and oriented and might not want their shower times changed. The UM reported that the DON did not direct her to review or speak with any specific resident. She also stated the DON never informed her that Resident #53 wanted to change his shower times. UM #1 indicated she did not start the process of reevaluating the shower schedule that had been put in place in January. The UM emphasized that it was the residents' right to choose their preferred shower days and shifts. UM #1 explained that her approach was to ask both the nursing assistants and the residents about their preferences and to accommodate them to the best of her ability.A phone interview was conducted on 04/16/2026 at 10:33 AM Resident #53's Family Member. She stated that Resident #53 had been requesting to have his showers changed back to 1st shift since January, after the new company assumed ownership and altered his schedule. She reported that he had made several requests, but the shower time was never returned to 1st shift. The family member stated that she requested to speak with the Director of Nursing (DON) approximately three weeks ago to ask why Resident #53's request had not been addressed. She reported that the DON told her she would evaluate the schedule and determine whether changes could be made. The Family Member indicated that the DON said she wanted the schedule to be convenient and provide structure. The Family Member emphasized that resident rights should be the priority.An interview was conducted on 04/15/26 at 9:40 AM with the Director of Nursing (DON). The DON confirmed that she created a new shower schedule in January to establish more structure and improve workflow. She acknowledged that she did not speak with residents prior to making the changes and stated her intent was to balance the number of showers scheduled between first and second shifts. The DON reported that approximately two weeks ago, Resident #53's family requested a meeting with her. During the meeting, the resident and his family asked that his showers be returned to 1st shift because it was his preference. The DON stated she told them she would look into the matter and see what could be done. Instead, she delegated the task to Unit Manager (UM) #1, instructing her to review the shower schedule and determine whether Resident #53's preference could be accommodated. The DON indicated resident rights should be honored.A phone interview was conducted on 04/19/26 at 4:39 PM with the Administrator. He stated that he expected resident rights to always be considered. He indicated that if a resident was alert and oriented and requested a change in their shower schedule, that request should be evaluated and granted whenever possible.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, the facility failed to provide maintenance services necessary to ensure resident bathrooms were in good repair and maintained in a safe, homelike manner. Damaged sheetrock, damaged floor tile, shower tile with visible blackish-brown substance present, and a broken ceramic toilet tank lid were observed for 1 of 4 sampled residents (Resident #15) on 1 of 4 halls (Hall #1).Findings included: A review of the census showed Resident #15 was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 1/28/2026.Resident #15's quarterly Minimum Data Set, dated [DATE] documented that he was cognitively intact.A review of facility work orders from 1/1/26 through 4/15/26 revealed one completed work order for room [ROOM NUMBER] on 3/20/26 (installation of a grab bar in the bathroom). No work orders were found for room [ROOM NUMBER]. No work orders were available prior to January of 2026.During an interview on 4/13/26 at 3:26 PM, Resident #15 stated he was admitted to room [ROOM NUMBER] in 2025 and recently moved to room [ROOM NUMBER] following a hospitalization. He described the bathroom in room [ROOM NUMBER] as being in poor condition, with dirty shower tile, no grab bar near the toilet, wall damage on the left wall by the toilet and shower, and a broken toilet tank lid. He stated he had not used the shower and did not know how long the bathroom had been in this condition. He recalled reporting these issues in the past but could not remember to whom. He added that the bathroom in room [ROOM NUMBER] was also in poor condition, with visible sheetrock patching on the walls and large spots on the painted tile floor.An observation of the bathroom in room [ROOM NUMBER] on 4/13/26 at 3:35 PM identified a tile shower with a blackishˆbrown substance covering approximately a 2 foot (ft) by 2.5 ft area on the shower floor and up the left wall. The wall between the toilet and shower had sheetrock damage at the base. A 2 ft by 4 ft piece of 1/4ˆinch wood had been screwed to the wall on the right side of the toilet. The ceramic toilet tank lid was broken, missing the bottom left corner.An observation of the bathroom in room [ROOM NUMBER] on 4/13/26 at 3:40 PM revealed sheetrock damage extending approximately 2.5 ft up the left wall beside the toilet. The door frame was damaged, with missing paint and rust visible from the floor up to 2.5 ft. The bathroom floor appeared to be tile that had been painted with a green layer and then a blue layer, with multiple areas of chipping paint exposing different colors beneath.During an interview and observation with the Maintenance Director on 4/16/26 at 10:16 AM, he stated that many rooms and bathrooms were already in this condition when the company assumed operations in January and appeared to have been this way for a long time. He acknowledged awareness of the condition of room [ROOM NUMBER]'s bathroom, explaining that water damage caused the tile and wall deterioration. He stated the toilet lid had not been broken during his last visit to the room and was unsure when it occurred. The Maintenance Director reported that since the new ownership assumed operations, maintenance projects had to be prioritized based on severity, and he stated they began addressing the highestˆpriority concerns first.During a second interview and observation with the Maintenance Director on 4/16/26 at 10:23 AM, he also acknowledged awareness of the condition of the bathroom in room [ROOM NUMBER] and stated that both the walls and floors needed significant repair.During an interview with Administrator #2 on 4/16/26 at 2:57 PM, he stated the facility was under new leadership and actively working to address ongoing repair needs. Administrator #2 stated he was aware that there were several rooms throughout the facility that needed repair and that the maintenance team was actively working on addressing them. He stated his expectation was for all rooms and bathrooms to be maintained in good repair and to provide a safe, homelike environment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with the Nurse Practitioner, resident and staff, the facility failed to schedule a follow-up appointment with dermatology for 1 of 3 residents reviewed for non-pressure related skin conditions (Resident #35). The findings included: Resident #35 was admitted to the facility on [DATE] with diagnoses that included diabetes and a history of basal cell carcinoma of the skin. A Nurse Practitioner (NP) progress note dated 12/9/25 indicated Resident #35 had a sore on top of the head. The NP documented a dermatology appointment was to be made by nursing. A NP progress note dated 1/27/26 read that Resident #35 was being seen for a wound to the top of his head. Wound was present from scratching and was the size of a nickel. New orders were provided for treatment of the healing wound to the top of his head. Resident #35 had a history of basal cell carcinoma to the head, neck and skin. Consults: dermatology consultation as needed for possible basal cell carcinoma on top of the head. Per Resident #35's physician orders, an order dated 1/27/26 indicated to wash the wound on top of his head with normal saline. Apply antibiotic ointment to the wound bed then Triamcinolone (an ointment that reduces itching, redness and swelling) cream to the surrounding skin daily and as needed. A review of the January 2026 Treatment Administration Record (TAR) revealed Resident #35 received the treatment as ordered to the wound on his scalp. A review of Resident #35's physician orders included an order dated 1/30/26 for a dermatology consult as needed for possible basal cell carcinoma on top of head. He had a history of basal carcinoma to head, neck and skin. The order was signed off as completed by Nurse #14. Multiple attempts to interview Nurse #14 by phone on 4/15/26 and 4/16/26 were not successful. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #35 was cognitively intact and received application of ointments/medications other than to his feet. An NP progress note dated 2/9/26 indicated Resident #35 was being seen that day by the NP for the wound to the top of his head. The NP documented the wound had healed and redness and swelling had decreased around the wound. The note indicated that an order was placed on 1/30/26 for a dermatology appointment. Plan: schedule a dermatology appointment to evaluate and treat the wound to the top of the head. History of basal cell carcinoma. A NP progress note dated 3/6/26 read that Resident #35 was being seen that day by the NP for a wound to the top of his head. The NP documented the wound to the top of his head remained healed; however, the wound bed and surrounding skin were red, inflamed and irritated. An NP progress note dated 3/30/26 indicated that Resident #35 was inquiring about the dermatology consultation for possible basal cell carcinoma or squamous cell carcinoma to the top of his head. The NP documented the wound had redness, inflammation and irritation surrounding the scabbed over wound to the top of the head and sometimes itched. An interview and observation occurred with Resident #35 on 4/13/26 at 10:41 AM. A scabbed area was noted to the top of his scalp. Resident #35 explained that he had a history of skin cancer and that he was told he needed to see the dermatologist a few months ago but wasn't sure if the appointment had been made yet. He indicated that he had an established dermatologist due to his history of skin cancer but had not had the need to go back to the clinic for a while. He explained that he developed an itchy spot to his scalp back in the winter which was made worse by scratching it. Resident #35 stated that he received a cream to the area that relieved the itching and caused the area to scab over when it first started in December 2025. Resident #35 stated that he had discussed the lack of his dermatology appointment with the NP many times and felt it had been forgotten about. Resident #35 stated that he had not reached out to the dermatology clinic on his own. On 4/15/26 at 9:00 AM, an interview occurred with the Resident Transportation staff member. She indicated that there was a staff member (former Resident Appointment Scheduler) that made all the resident appointments but had not worked at the facility since the beginning of 2026. The Resident Transportation staff member stated that she had been making resident appointments since January 2026 and was not aware that Resident #35 needed a dermatology appointment. She explained (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that if a resident needed an appointment the nurse would print out the referral or NP order and provide it to the appointment scheduler, which was the Resident Transportation staff member at the time of the interview. She was unable to locate a referral for Resident #35 to be seen by dermatology. Multiple attempts to interview the former Resident Appointment Scheduler by phone on 4/15/26 and 4/16/26 were not successful. Another interview occurred with the Resident Transportation staff member on 4/15/26 at 10:06 AM, who indicated she called the dermatology clinic and was told they had received a referral (date unknown) and had called the previous staff member that was responsible for making resident appointments requesting further information. The dermatology clinic stated they had never heard back from that staff member. The Resident Transportation staff member stated she would collect the needed information to make the appointment for Resident #35. The NP was interviewed on 4/15/26 at 9:27 AM and stated she had been assessing Resident #35's wound on the top of his head since December 2025 and had requested a dermatology appointment due to his history of basal cell carcinoma. She stated she was not sure if the appointment had been made but would still like Resident #35 to follow up with dermatology. She explained she would have let the Unit Manager know if someone needed an appointment with a specialist and the nursing staff should have ensured this appointment was made. The NP did not feel this was an urgent matter as the area to the scalp had healed but would have liked for him to follow-up with dermatology due to his history of basal cell carcinoma. Unit Manager #1 was interviewed on 4/15/26 at 9:42 AM and explained if a resident needed an appointment made with a specialist, the referral or order would have been printed out and provided to the resident appointment scheduler. Unit Manager #1 was unsure if a dermatology appointment had been made for Resident #35 and could not recall if she had been made aware at the time the order was written on 1/30/26. The Director of Nursing (DON) was interviewed on 4/16/26 at 9:49 AM and explained she started working at the facility towards the end of January 2026. She stated referrals or orders should have been printed out and provided to the resident appointment scheduler for Resident #35 to have a scheduled dermatology appointment. She stated there was a change in the staff member scheduling resident appointments prior to her becoming the DON and was unaware that Resident #35 had not been scheduled to see the dermatology clinic or that there was an order written on 1/30/26 for him to be seen by dermatology. The DON indicated that currently the Resident Transportation staff member was responsible for making resident appointments, but this would be transitioned to the Medical Records staff member in the next few months. She stated this person had only been at the facility for a few weeks and that was the reason for the delay in transferring responsibilities. The Administrator was interviewed on 4/16/26 at 12:15 PM and indicated that it was his expectation for resident appointments to be scheduled in a timely manner.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Nurse Practitioner and staff interviews, the facility failed to assess and obtain treatment orders for a resident admitted from the hospital with a pressure ulcer for 1 of 8 residents reviewed for pressure ulcers (Resident #125).The findings included: A review of the hospital records for Resident #125 from 12/31/25 to 1/23/26 indicated a hospital-acquired unstageable pressure injury was present to the sacrum. The discharge summary did not contain any type of wound care orders for the sacral pressure injury. Resident #125 was admitted to the facility on [DATE] (Friday) with diagnoses that included end stage renal disease on hemodialysis and pressure ulcer of the sacral region. Review of the admission assessment and nursing progress note dated 1/23/26, completed by Nurse #13, indicated skin impairment to the coccyx was present on admission to the facility and was marked as unstageable. There were no other details in the progress note describing the skin impairment. Attempts to contact Nurse #13 via the phone were unsuccessful from 4/15/26 to 4/16/26. A review of Resident #125's care plan included a focus area dated 1/23/26 for having skin impairment. The interventions included treatment as ordered. A phone interview was conducted with Nurse #7 on 4/16/26 at 1:36 PM, who was assigned to care for Resident #125 from 7:00 AM to 7:00 PM on 1/24/26. She stated that she couldn't recall providing wound care to Resident #125 on that day. She indicated if there was an order she would have completed the wound care, if there was no order present, she would not have known to complete any wound care. Attempts to contact Nurse #8 via the phone from 4/15/26 to 4/16/26 were unsuccessful. Nurse #8 was scheduled to care for Resident #125 from 7:00 AM to 7:00 PM on 1/25/26. A phone interview occurred with Nurse #3 on 4/16/26 at 1:13 PM. She was assigned to care for Resident #125 from 7:00 AM to 7:00 PM on 1/26/26. She indicated that she did not provide wound care to Resident #125 on that day. An admission skin assessment dated [DATE] was completed by Nurse #5 who was the wound care nurse. The assessment documented a pressure ulcer was present to the sacrum measuring 2 centimeters (cm) in length and 2 cm in width. A phone interview was conducted with Nurse #5 on 4/15/26 at 1:25 PM, who was also the wound care nurse in January 2026. She explained that when a resident was admitted to the facility the nurse would do an initial assessment and transcribe any wound care orders present on the hospital discharge summary. If wound care orders were not present the nurse should have reached out to the NP or on-call provider to obtain wound care orders. She went on to say that as the wound care nurse she completed a skin assessment within 24 hours of admission during the week or on Monday if the admission occurred late on Friday or the weekend and ensured that treatment orders were appropriate and transcribed correctly. Nurse #5 could not recall why she completed the skin assessment on Tuesday 1/27/26 rather than Monday but stated she reviewed the hospital discharge summary for Resident #125 who had a sacral pressure ulcer on admission. Nurse #5 stated that when she completed the skin assessment, she recalled the bandage to Resident #125's sacral wound was from the hospital and there were no wound care orders on her Treatment Administration Record (TAR). Nurse #5 could not recall if she had reported this to anyone. A review of Resident #125's physician's orders included an order dated 1/27/26 to cleanse the sacral pressure ulcer with 1/4 strength Dakin's solution (a highly diluted, antiseptic bleach solution used to clean skin wounds to treat or prevent infection) and pat dry. Apply calcium alginate (a highly absorbent wound dressing to promote healing) to the wound bed and cover with super absorbent foam daily and as needed. This order was entered by Nurse #5 who was wound care nurse at that time. A review of Resident #125's January 2026 Treatment Administration Record (TAR) revealed the first documented treatment provided to the sacral pressure ulcer was on 1/27/26. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #125 had severely impaired cognition and was coded with one unstageable pressure ulcer that was present on admission. Resident #125 transferred to the hospital on 2/11/26 from dialysis due to respiratory concerns. On 4/15/26 at 9:27 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Pest Control Technician interviews, the facility failed to maintain an effective pest control program as evidenced by the presence of roaches for 1 of 3 observations in the kitchen. Findings included:Pest control summary of services from the pest control service were reviewed for the following dates of 09/09/25, 09/16/25, 09/30/25, 10/07/25, 10/14/25, 10/21/25, 11/05/25, 11/21/25, 11/25/25, 12/02/25, 12/10/25, 12/17/25, 12/30/25, 01/06/26, 01/13/26, 01/20/26, 01/28/26, 02/04/26, 02/17/26, 02/25/26, 03/03/26, 03/11/26, 03/24/26, 03/31/26, and 04/09/26.The following general comments/instructions were documented on the summary of services:-09/09/25- Spot treated kitchen, underneath cooking equipment, dishwasher area, restrooms, dining area, and office for general pest control. German roach activity was found in the electrical box in the dishwasher, near the coffee station, and the heating warmer for the food. Cracks in the wall, floor, and ceiling tiles need to be repaired, this is causing a harboring site for roaches. Roach gel bait was applied to the cracks and crevices of broken tiles. Treated room [ROOM NUMBER], human resource office, and soiled linen room. Target pests: German roaches, and general pest control in cracks and crevices and spot inside treatment.-09/16/25- Spot treated kitchen, underneath cooking equipment, dishwasher area, restrooms, dining area, and office for general pest control. German roach activity. Target pests: German roaches and general pest control, spot inside treatment.-09/30/25- Spot treated kitchen, underneath cooking equipment, dishwasher area, restrooms, dining area, and office for general pest control and German roaches. Repairs are needed, cracks, broken floor tiles and base boards, standing water due to drains not working properly, and greasy cooking equipment should be degreased, these issues are providing harboring sites for German roaches and causing control methods to fail. room [ROOM NUMBER] was fogged per the manager and maintenance technicians request for german roaches. Maintenance Director was informed to put a DO NOT ENTER sign on the door so that staff and residents would not enter. Treated room [ROOM NUMBER] and the activity room for general pest control. Target pests: German roaches and general pest control, spot inside treatment and space treatment.-10/07/25- General pest control roaches interior and exterior doorways. Treated business office, social worker office, sunshine room, conference room, activity room, nursing stations, laundry room, central supply room, soiled linen room, unit manager office, dayroom, administrative office, transportation office, human resource office, receptionist office, and admissions office for general pest control. Treated rooms 49, 47, 41, 40, 37, 35, 29, 30, 15, 72, 63, 64, 69, 70, 10, 7, 5, 4, and 3 for general pest control. Spot treated kitchen, underneath cooking equipment, dishwashing era, restrooms, dining room area, and office for general pest control.-10/14/25 and10/21/25- Spot treated kitchen, underneath cooking equipment, dishwashing era, restrooms, dining room area, and office for general pest control.-11/05/25- General pest control roaches-interior and exterior doorways. Technician spot treated the interior foundation of the building with insecticide including bathrooms, kitchen, laundry room, bedrooms, brick room, offices, and doorways.-11/21/25 and 03/31/26- General pest control. Target pests: Cockroach other than American-11/25/25- General pest control. Target pests: Rat and Mice-12/02/25 and 02/04/26- General pest control roaches-interior and exterior doorways-12/23/25, 01/06/26 and 01/20/26- General pest control.-12/17/25 and 12/30/25- General pest control. Target pests: Bed bugs-01/13/26 and 01/28/26- General pest control. Target pests: Rats-02/17/26- General pest control. Technician spot treated the interior foundation of the building with insecticide including kitchen, common areas, multipurpose room, and doorways. Technician also replaced bait in rodent stations where needed throughout the building.-02/25/26- General pest control. Technician spot treated the interior foundation of the kitchen with insecticide including storage rooms, dish area, and office.-03/03/26- General pest control roaches-interior and exterior doorways. (Please contact Maintenance Director on each visit, he will need to walk the technician through-no exceptions). Technician spot treated the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durham Nursing & Rehabilitation Center	411 S Lasalle Street Durham, NC 27705

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interior foundation of the building with insecticide including bathrooms, kitchen, rehabilitation room, activities room, nurse's stations, and offices in multipurpose room.-03/11/26 and 03/24/26- General pest control roaches-interior and exterior doorways. (Please contact Maintenance Director on each visit, he will need to walk the technician through-no exceptions). Technician spot treated the interior foundation of the kitchen with insecticide including storage room and doorways.-04/09/26- General pest control roaches-interior and exterior doorways. Target Pests: ants and bed bug (Please contact Maintenance Director on each visit, he will need to walk the technician through-no exceptions). Technician spot treated the interior foundation of the building with insecticide including bathrooms, kitchen, rehabilitation room, doorways, nurse's stations, and offices in multipurpose room.Review of Dietary Stand-up Meeting Reports documented by the Dietary Manager revealed Pest Sightings: some for the following dates: 02/28/26, 03/02/26, 03/03/26, 03/04/26, 03/09/26, 03/10/26, 03/12/26, 03/16/26, 03/26/26, 03/30/26, 04/01/26, 04/06/26, 04/07/26, 04/08/26, and 04/09/26.During a kitchen observation with the Dietary Manager (DM) on 04/15/2026 at 11:25 AM, a live roach was on the floor in front of the dry storage doorway in the kitchen. The roach proceeded into the dry storage area. This was observed by both the surveyor and the DM. An interview and concurrent observation were conducted with the DM regarding the live roach activity. She stated that they do have ongoing live roach activity and that she typically sees roaches under the steam table and in other warm areas. An inspection of the area beneath the steam bar revealed multiple layers of food debris, a dessert cup covered with plastic wrap containing food, disposable lids, a fork, dust, and dirt. The area appeared not to have been cleaned. The DM explained that she kept a log of pest sightings in her office and would also complete a The DM explained that she had reported the roach sitings when they were observed to Administrator #2. The DM indicated the pest control technician was on sight on the evening of 04/14/26 and did treat the kitchen area for roaches.Review of Pest Control Logs provided by the Dietary Manager revealed the following: 03/31/26-Bottom of gas oven and dish room. 04/09/26-Door at front, spray for flies, cart area, ants around steamtable, and gas stove. Pest control came on 04/14/26.On 04/16/26 at 9:23 AM, a followˆup interview was conducted with the Dietary Manager (DM). The DM stated she did not have a formal deepˆcleaning schedule for the kitchen and that she had staff perform deep cleaning periodically. She explained that she expected staff to clean as they worked in order to keep areas tidy. The DM indicated the Pest Control Logs she had provided was in reference to roach sightings unless otherwise specified.On 04/15/26 at 11:43 AM, an interview was conducted with Cook/Aide #1. He stated that he sees live roaches regularly but ignores them. He also reported that the roach activity had improved slightly over the past few months.On 04/15/26 at 1:01 PM, an interview was conducted with Dietary Aide #2. He stated that he had seen live roaches regularly; however, he noted that the activity was not as severe as it had been before December 2025 when the new facility owners took over.On 04/15/26 at 1:02 PM, an interview was conducted with Dietary Aide #3. She stated that she had seen live roaches regularly; however, she noted that the activity was not as severe as it had been before December 2025 when the new facility owners took over. Dietary Aide #3 also reported that there was a notebook in the Dietary Manager's (DM's) office where staff document the date and location of any live roach activity observed.On 04/15/26 at 1:14 PM, a phone interview was conducted with the Pest Control Technician. He stated that he treats the facility weekly according to a structured schedule. During the first week of each month, he treats the common areas of the facility, which include personal offices, nurses' stations, common bathrooms, and breakrooms, as well as any specific resident rooms identified by the Maintenance Manager. He stated that every other week he treats the kitchen in addition to any resident rooms requested by the Maintenance Manager. The Technician reported that he has seen improvement in the live roach activity but stated that active infestation remains. The Pest Control Technician then stated he normally sees at least one (1) live roach when he was conducting the pest control treatment. He explained that the ongoing issue was due to sanitation problems in the kitchen and the facility's failure to address his recommended repairs. These concerns include holes in walls, cracked tiles and (continued on next page)

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	345070	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	crevices, and open areas around pipes. He described that the open areas around the pipes lacked insulation or caulking, and the cracks and holes have not been repaired. He further stated that there were consistently food crumbs, flour, dough, and other food debris on the floor, which provided a food source for roaches. He emphasized that if these areas were not kept clean, roaches would choose the actual food over the bait every time. The Pest Control Technician noted that while some areas of the kitchen were clean at times, no sustained deep cleaning had been maintained. Areas behind equipment, under shelves, and beneath the steam bar had layers of food debris, dust, and dirt that appeared not to have been cleaned for a very long time. The Technician reported that no repairs have been completed, except for a border placed around the freezer, which does not fully seal or touch the freezer. He stated that he had communicated these concerns to the Maintenance Director during every visit and had spoken to Administrator #2 in the past (did not recall exact date) related to above the concerns. The Pest Control Technician added that the Maintenance Director accompanied him during the pest control treatments.On 04/15/26 at 9:33 AM, an observation and interview were conducted with the Maintenance Director during a tour of the kitchen. The Maintenance Director stated that he did accompany the Pest Control Technician during the pest control treatments. The Maintenance Director also stated he was aware of issues in the kitchen, including holes, cracks, and damaged trim or molding that required repair; however, he had not yet completed the repairs. He stated he had been employed at the facility since January and that several areas throughout the facility required attention. He also reported that two new maintenance helpers had started approximately two weeks ago. During the tour, the Maintenance Director identified multiple areas in the kitchen needing repair and stated, it will be addressed at some point. He verified the presence of large open areas around plumbing pipes under three sinks, a water leak under the sink on the back wall of the kitchen, damaged trim and molding at doorway entrances and around the cooler and freezer, peeling paint on the ceiling above the racks near the kitchen entrance door, and damaged tile along the wall corners. He stated that maintaining cleanliness in the kitchen was the responsibility of the kitchen staff.On 04/16/26 at 2:54 PM, an interview was conducted with Administrator #2. Administrator #2 stated he was aware that repairs, cleaning issues, and pest sightings had been occurring in the kitchen, and that the Dietary Manager (DM) reported these concerns during morning standˆup meetings. He explained that while the DM reported that cleaning was being completed, he did not verify that the work was being done. Administrator #2 indicated he did not make routine rounds in the kitchen. He went on to say he reviewed the pest service summaries and that he was comparing prices with other pest control companies for a possible change of pest control companies. Administrator #2 explained that the kitchen should be kept as clean as possible throughout the day, thoroughly cleaned at the end of the day, and that any holes, defects, or damages should be repaired as soon as possible to reduce pest activity. He stated he expected the kitchen to remain free of crumbs and debris throughout the day and for staff to clean as they worked. Administrator #2 reported that the plan was to correct and repair all identified areas of concern.