DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-NEUSE STREET ADDRESS, CITY, STATE, ZIP CODE 130 HEALTH DRIVE NEW BERN, NO. 28560 SOLID HARD TO BE PROVIDED BY PAUL OF CORRECTION OF COMPLETE TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) FOR INITIAL COMMENTS The survey team entered the facility on 03/30/2021 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 03/31/2021. Therefore, the exit date was 03/31/2021. Therefore, the Complaint allegations were unsubstantiated. Event IDW Z3QT11.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-NEUSE STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560			345357	B. WING		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOUR TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOUR TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOUR TAG FOUR TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOUR TAG FOUR TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOUR TAG FOUR TAG FOUR TAG COMPLET TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					1303 HEALTH DRIVE	
The survey team entered the facility on 03/30/2021 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 03/31/2021. Therefore, the exit date was 03/31/2021. 11 of the 11 complaint allegations were unsubstantiated.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						

04/02/2021 **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.