**Statement of Deficiencies and Plan of Correction**

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

345566

**State:**

08/08/2019

**Date Survey Completed:**

07/25/2019

**Name of Provider or Supplier:**

PRUITTHEALTH-UNION POINTE

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

3510 WEST HIGHWAY 74
MONROE, NC  28110

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>An unannounced recertification and complaint investigation survey was conducted on 07/22/19 - 07/25/19. The facility was found in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID: 8O1511</td>
</tr>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). An unannounced recertification survey and complaint investigation survey was conducted from 7/22/19 - 7/25/19. There was a total of 7 allegations investigated and they were all unsubstantiated. Event 8O1511.</td>
</tr>
</tbody>
</table>

**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.