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

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F 000 INITIAL COMMENTS F 000 An unannounced complaint investigation survey was conducted on 06/27/22 through 06/28/22. Event ID# 78YT11. The following intake was investigated: NCO189590. 2 of the 2 complaint allegations were not substantiated.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			
ACCORDIUS HEALTH AT WILMINGTON DIATID CHAILD CHAILD			345236	B. WING _				
CAMPID PRETIX REMAINS TO BE PRECIDED BY FULL PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX PROVIDERS PLAN OF CORRECTION CAPACH CORRECTION CAPACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SH	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		1 00.	
MILMINGTON, NC 28401					820 WE	ELLINGTON AVENUE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FROM INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 06/27/22 through 06/28/22. Event ID# 7RYT11. The following intake was investigated: NC0018950. 2 of the 2 complaint allegations were not substantiated.	ACCORDIUS HEALTH AT WILMINGTON				WILMINGTON, NC 28401			
An unannounced complaint investigation survey was conducted on 06/27/22 through 06/28/22. Event ID# 7RYT11. The following intake was investigated: NCO0189590. 2 of the 2 complaint allegations were not substantiated.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION
was conducted on 06/27/22 through 06/28/22. Event ID# 7RYT11. The following intake was investigated: NC00189590. 2 of the 2 complaint allegations were not substantiated.	F 000	INITIAL COMMENTS		F	000			
		was conducted on 06 Event ID# 7RYT11. The following intake NC00189590. 2 of the 2 complaint a	6/27/22 through 06/28/22.					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								

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.

Electronically Signed

07/11/2022