

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/07/2025
NAME OF PROVIDER OR SUPPLIER TRUEWOOD BY MERRILL, NEW BERN MEMOIF			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 AMHURST BOULEVARD NEW BERN, NC 28562		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{C 000}	Initial Comments Construction Section Biennial Follow-Up Survey by Ryan Meyer conducted on January 7, 2025. All deficiencies have been repaired. No further action required.	{C 000}			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE