**Statement of Deficiencies and Plan of Correction**

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

345115

**Date Survey Completed:**

11/08/2018

**Multiple Construction Building:**

A. Building _______________________

B. Wing _______________________

**Name of Provider or Supplier:**

Accordius Health at Salisbury

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

635 Statesville Boulevard
Salisbury, NC 28144

### Summary Statement of Deficiencies

**ID**

<table>
<thead>
<tr>
<th>Prefix Tag</th>
<th>Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>A paper revisit was conducted on 11/8/18. The facility is in compliance as of 11/26/18.</td>
</tr>
</tbody>
</table>

**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

Electronically Signed

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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.

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**Event ID:** SYYQ12  
**Facility ID:** 953007  
**If continuation sheet Page:** 1 of 1