## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/CLIA Identification Number:

- **A. Building:**
  - **Identifying Number:**
  - **State:**
  - **City:**
  - **Zip Code:**

### Multiple Construction

- **Wing:**

### Date Survey Completed

- **R-C:**
  - **Date:** 04/17/2019

### Name of Provider or Supplier

- **Accordius Health at Lexington**

### Street Address, City, State, Zip Code

- **279 Brian Center Drive**
  - **Lexington, NC 27292**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>An onsite follow up was conducted on 4/17/19. The facility is back in compliance as of 4/9/19.</td>
</tr>
</tbody>
</table>

### Provider’s Plan of Correction

- **(X4) ID Prefix Tag**
- **(X5) Completion Date**

### Laboratory Director’s or Provider/Supplier Representative’s Signature

- **Electronically Signed**

**Note:** 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.