**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ____________________________**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345115

**NAME OF PROVIDER OR SUPPLIER**

ACCORDIUS HEALTH AT SALISBURY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

635 STATESVILLE BOULEVARD

SALISBURY, NC  28144

**ID**

**PREFIX**

**TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
</tbody>
</table>

A complaint survey was conducted from 08/20/19 through 8/21/19.

1 of the 5 complaint allegations were substantiated but did not result in a deficiency.

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

Electronically Signed

09/03/2019

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.