STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345208

MULTIPLE CONSTRUCTION

BUILDING __________________________

WING _____________________________

DATE SURVEY COMPLETED

C

11/25/2019

NAME OF PROVIDER OR SUPPLIER

ACCORDIUS HEALTH AT BREVARD

STREET ADDRESS, CITY, STATE, ZIP CODE

115 N COUNTRY CLUB ROAD

BREVARD, NC  28712

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

PRINTED:  01/15/2020

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

Electronically Signed

DATE

12/13/2019

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)

ID

PREFIX

TAG

COMPLETION DATE

F 000 INITIAL COMMENTS

An on site revisit and complaint investigation survey was conducted on 11/25/19. There were two allegations were investigated and both were not substantiated. Event ID R7W111

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R7W111

Facility ID: 922995

If continuation sheet Page 1 of 1

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.