## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345011

**Date Survey Completed:** 01/22/2020

**Name of Provider or Supplier:** Accordius Health at Lexington

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

### Summary Statement of Deficiencies

**Deficiency:** F 000

**Initial Comments:**

An on-site recertification/complaint investigation follow up was conducted in conjunction with a new intake complaint investigation at the facility from 1/21/20 through 1/22/20 see event ID# 6GYZ11 for the new intake complaint investigation. All twenty of the allegations were investigated on-site and all were unsubstantiated. See Event ID# 8NXD12 for information regarding the recertification/complaint investigation follow up.

### Provider's Plan of Correction

**Completion Date:**

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

Electronically Signed 02/03/2020

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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.*