**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING ____________
- MULTIPLE CONSTRUCTION B. WING ____________
- DATE SURVEY COMPLETED: C. 05/20/2020

**NAME OF PROVIDER OR SUPPLIER**

ACCORDIUS HEALTH AT WILSON

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

1804 FOREST HILLS ROAD W

WILSON, NC 27893

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments An unannounced COVID-19 Focused Survey was conducted on 5/20/19. The facility was found in Compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID# WGMJ11</td>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS An unannounced Infection Control Focused Survey and complaint investigation survey was conducted on 5/20/19. No deficiencies were cited. Event ID# WGMJ11</td>
<td>F 000</td>
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</tbody>
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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed 05/26/2020

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.