### Statement of Deficiencies and Plan of Correction

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

345359

**Date Survey Completed:**

R-C 10/30/2020

#### Name of Provider or Supplier

**Accordius Health at Creekside Care**

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

604 Stokes Street East
Ahoskie, NC 27910

#### 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>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(F 000)</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>An onsite revisit was conducted on 10/29/20-10/30/20 and the facility is back in compliance effective 10/3/20. The Directed Plan of Correction and the Root Cause Analysis were reviewed.</td>
</tr>
</tbody>
</table>

#### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

#### Initial Comments

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.

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

**Title**

Electronically Signed 11/03/2020