**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

ACCORDIUS HEALTH AT WILSON

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

1804 FOREST HILLS ROAD W
WILSON, NC 27893

**ID PREFIX TAG**

(F 000) INITIAL COMMENTS

Two paper revisits were conducted on 7/23/21. The facility is in compliance as of 6/15/21, the later date chosen by the facility for the tags being reviewed.

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

Electronically Signed

**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.**