### 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**

#### Statement of Deficiencies

**F 000 Initial Comments**

An onsite revisit was conducted on 5/03/22 and the facility is back into compliance effective 3/25/22.

#### Provider's Plan of Correction

**(Each corrective action should be cross-referenced to the appropriate deficiency)**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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#### Laboratory Director's or Provider/Supplier Representative's Signature

**Title**

Electronically Signed

**Date**

05/09/2022

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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.

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

Event ID: VZQN12

Facility ID: 922960

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