## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-0391

R-C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CLEMMONS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  An onsite follow up investigation was completed 12/06/2022 through 12/07/2022. The facility was			245424						
ACCORDIUS HEALTH AT CLEMMONS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  An onsite follow up investigation was completed 12/06/2022 through 12/07/2022. The facility was				B. WING				12/07/2022	
CLEMMONS, NC 27012  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  An onsite follow up investigation was completed 12/06/2022 through 12/07/2022. The facility was	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE								
(X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  An onsite follow up investigation was completed 12/06/2022 through 12/07/2022. The facility was	ACCORDIUS HEALTH AT CLEMMONS				3905 CLEMMONS ROAD				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000 INITIAL COMMENTS  An onsite follow up investigation was completed 12/06/2022 through 12/07/2022. The facility was	ASSOCIATION DELINING				CLEMMONS, NC 27012				
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12/06/2022 through 12/07/2022. The facility was	F 000	00 INITIAL COMMENTS		F	000				
		12/06/2022 through 1	2/07/2022. The facility was						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X6) DAT	ADODATODY		QUIDDI IED DEDDEQENTATIVE'S QUANTUD		TITLE			(X6) DATE	

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.