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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

345132

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY
COMPLETED
C
03/22/2012

NAME OF PROVIDER OR SUPPLIER
GREENHAVEN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
601 GREENHAVEN DR
GREENSBORO, NC 27406

(X4) ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

No Deficiencies cited as a result of the complaint
The facility is in compliance with requirements of
42 CFR Part 483, Subpart B for Long Term Care
Facilities (General Health Survey).

ID
PREFIX
TAG

F 000

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

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

TITLE

(X5) COMPLETION
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.

FORM CMS-2587(02-09) Previous Versions Obsolete
Event ID: W2UO11
Facility ID: 923238
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