### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier

GUILFORD HEALTH CARE CENTER

#### Street Address, City, State, Zip Code

2041 WILLOW ROAD
GREENSBORO, NC  27406

#### ID, Prefix, Tag

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<td>INITIAL COMMENTS</td>
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The Ci was conducted on 2/23/20-2/24/20, Event ID 27LU11. [x] _5_ of the _5_ complaint allegations were not substantiated.

#### Laboratorv 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.