## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345273

**Multiple Construction:**

**A. Building:**

**B. Wing:**

**Date Survey Completed:** 05/21/2020

**Printed:** 06/23/2020

**Form Approved:**

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**Name of Provider or Supplier:** Kindred Hospital East Greensboro

**Street Address, City, State, Zip Code:** 2401 South Side Boulevard, Greensboro, NC 27406

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### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
<td>An unannounced COVID-19 Focused Survey was conducted on 5/18/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 8E4711</td>
</tr>
<tr>
<td>F 000</td>
<td>Initial Comments</td>
<td></td>
<td>An unannounced Complaint Investigation and COVID-19 Focused Survey was conducted on 5/18/2020. 2 out of 2 complaint allegations was not substantiated. Event ID# 8E4711</td>
</tr>
</tbody>
</table>

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

**Date:** 06/01/2020

**Electronically Signed:**

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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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**Event ID:** 8E4711

**Facility ID:** 953348

**If continuation sheet Page:** 1 of 1