

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

PRINTED: 06/30/2025
FORM APPROVED
OMB NO. 0938-0391

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|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345014 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 06/12/2025 |
| NAME OF PROVIDER OR SUPPLIER LINDEN PLACE CENTER FOR NURSING AND REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | <p>INITIAL COMMENTS</p> <p>An onsite complaint investigation survey was conducted from 6/10/25 through 6/11/25. Additional information was obtained offsite on 6/12/24 therefore the exit date was moved to 6/12/25. Event ID # KZKI11. The following intake was investigated NC00231050.</p> <p>2 of 2 allegations did not result in a deficiency.</p> | F 000 | | | |

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

TITLE

(X6) DATE

Electronically Signed

06/13/2025

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.