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

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

|  | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                       | l l     | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED |                            |  |  |
|--|---|---------|---|-------------------------------|----------------------------|--|--|
|  | 34G252  | B. WING |   |                               | R<br><b>02/06/2019</b>     |  |  |
| NAME OF PROVIDER OR SUPPLIER  RIDGELY OAK  |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE  1307 WESTRIDGE RD  GREENSBORO, NC 27410                    |                               |                            |  |  |
| PREFIX (EACH DEFICIENCY MUS  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL                         |         | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |  |  |
| W 000 INITIAL COMMENTS  A revisit was conducted of previous deficiencies cited deficiencies have been connocompliance was found compliance with all regular. | d on 11/14/18. All<br>orrected, and no new<br>d. The facility is in | WO      |   |                               |                            |  |  |

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

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.

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                         |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED |              |
|---|--|---|---------------------|--|--|-------------------------------|--------------|
|   |  | 34G252  | B. WING             |  |  | 02/0                          | R<br>06/2019 |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1307 WESTRIDGE RD<br>GREENSBORO, NC 27410 | E  | , 02/0                        |              |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                               |              |
| W 000   | Continued From page  | ÷ 1   | W 00                |  |  |                               |              |
|   |  | cited on 11/8/18. All<br>an corrected, and no new<br>ound. The facility is in |                     |  |  |                               |              |

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|  |  | 34G252   | B. WING  |  | l l     | R                             |  |
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