DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			C	MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(	X3) DATE SURVEY COMPLETED		
		34G252	34G252 B. WING			R 01/17/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIF	P CODE			
RIDGELY	OAK			1307 WESTRIDGE RD				
RIDGELT	UAK			GREENSBORO, NC 27410				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE		
W 000	INITIAL COMMENTS		wo	000				
	deficiencies have bee	cited on 11/14/18. All en corrected, and no new ound. The facility is in						
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	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.

PRINTED: 02/13/2019

		ID HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R 01/17/2019		
		34G252 B. WING						
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1307 WESTRIDGE RD				
				GREENSBORO, NC 27410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			D PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE IG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
W 000	Continued From page	≥ 1		0000	DEFICIENCY)			
		cited on 11/8/18. All en corrected, and no new ound. The facility is in						

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PRINTED: 02/13/2019

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/13 FORM APPRO OMB NO. 0938-	OVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G252	B. WING _		_	R 01/17/2019	,	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE				
RIDGELY	OAK			1307 WESTRIDGE RD				
	Ι			GREENSBORO, NC 27410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		ETION	

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Event ID: WP3H12

Facility ID: 922011

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