DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		34G161	B. WING				R 01/2019
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GUILFORI	ר#1			4	16 BOXWOOD DRIVE		
GOILI OK	5 # 1			G	GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	;	W	000			
		cited on 8/6/19. All en corrected, and no new ound. The facility is in					
_ABORATORY 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: 11/01/2019

		D HUMAN SERVICES			FOF	M APPROVED
		MEDICAID SERVICES				O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
			A. BUILDIN	NG		R
		34G161	B. WING		1	к I/01/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/01/2013
				416 BOXWOOD DRIVE		
GUILFORI) #1			GREENSBORO, NC 27410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			ECTION	(X5)	
PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH			COMPLETION DATE		
TAG	REGULATORT OR L		TAG	DEFICIENCY)	ROTRIAL	
W 000	Continued From page	2 1	wo	000		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: B1YN12

Facility ID: 921934

If continuation sheet Page 2 of 4

PRINTED: 11/01/2019

		ID HUMAN SERVICES			FORM APPROV	VED	
		MEDICAID SERVICES			OMB NO. 0938-0	391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	IG	R		
		34G161	B. WING		11/01/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
				416 BOXWOOD DRIVE			
GUILFOR	D #1			GREENSBORO, NC 27410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION						
PRÉFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO						
170				DEFICIENCY)			
W 000	Continued From page	2	wo	00			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: B1YN12

Facility ID: 921934

If continuation sheet Page 3 of 4

PRINTED: 11/01/2019

	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 11/01/2019 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G161	B. WING			R 11/01/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
GUILFOR	D #1			416 BOXWOOD DRIVE	10		
		ATEMENT OF DEFICIENCIES		GREENSBORO, NC 2741	PLAN OF CORRECTION	(75)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
W 000	Continued From page	e 3	w 00	o			
		cited on 8/6/19. All en corrected, and no new					
	compliance with all re	ound. The facility is in gulations surveyed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 4 of 4