

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0552</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/02/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATIO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27408</b>		
(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) COMPLETE DATE
D 000	Initial Comments  No deficiencies were cited as a result of the state complaint investigation survey 7/2/11, Event ID # 9D4J11.	D 000		

Division of Health Service Regulation

TITLE

(X6) DATE

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

STATE FORM

6899

9D4J11 923456-2

If continuation sheet 1 of 1