PRINTED: 10/27/2025
FORM APPROVED

Division of Health Service Regulation

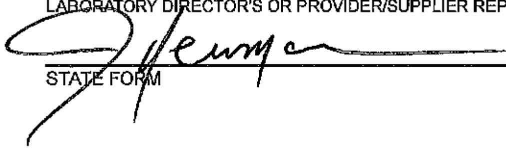
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0554	A. BUILDING: ______ B. WING ______	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOME WEST	6100 W FRIENDLY AVENUE 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS An unannounced onsite re-licensure survey and complaint investigation were conducted on 10/7/25 through 10/9/25. The facility is in compliance with the requirements of 10A NCAC 13D, the Rules for the Licensing of Nursing Homes. The following intake was investigated NC00205852. 2 of 2 allegations did not result in deficiency. No deficiencies were cited on this re-licensure survey and complaint investigation. Event ID# B46911.	L 000		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE



Associate Executive Director of Healthcare Services   10/27/25