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
	NH0546	A. BUILDING: ______ B. WING ______	C 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELL SPRING	**3560 WILDFLOWER DRIVE** **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 from 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 NC00232505. 4 of 4 allegations did not result in a deficiency. No deficiencies were cited on this re-licensure survey and complaint investigation. Event ID#1MJR11.	L 000		

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