DEPARTMENT OF HEALTH AND HUMAN SERVICES						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION						
CORRECTION	DENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	345152	B. WING			R 07/19/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	07/19/2018	
/ILLAGE			1265 21 STREET NE			
			HICKORY, NC 28601			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	( (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
INITIAL COMMENTS	i	FC	000			
Regulation Nursing H Certification Section of up survey. The facilit	lome Licensure and conducted an onsite follow ty was found to be in					
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER //ILLAGE //ILLAGE INITIAL COMMENTS On July 19, 2018, Th Regulation Nursing H Certification Section of up survey. The facilit	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345152    ROVIDER OR SUPPLIER          VILLAGE    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         A. BUILDIN         345152         ROVIDER OR SUPPLIER         //ILLAGE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         F O         On July 19, 2018, The Division of Health Service Regulation Nursing Home Licensure and Certification Section conducted an onsite follow up survey. The facility was found to be in	INITIAL COMMENTS       INITIAL COMMENTS         INITIAL COMMENTS       F 000         INITIAL COMMENTS       F 000         INITIAL COMMENTS       F 000         INITIAL COMMENTS       F 000	S FOR MEDICARE & MEDICAID SERVICES       ON         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3)         GOVIDER OR SUPPLIER       345152       B. WING       (X3)         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       1265 21 STREET NE HICKORY, NC 28601         MILLAGE       ID       PROVIDER'S PLAN OF CORRECTION (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         INITIAL COMMENTS       F 000       F 000         On July 19, 2018, The Division of Health Service Regulation Nursing Home Licensure and Certification Section conducted an onsite follow up survey. The facility was found to be in       F 000	

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: 07/30/2018

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Division of Health Service Regu STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NH0068	B. WING		C 07/19/2018		
IAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE, ZIP CODE				
RINITY V	/ILLAGE		STREET NE RY, NC 28601				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
		cited as a result of the on. Event ID #E2FQ11.					