		POST	-CERT	<b>TFICATIO</b>	N REVISI	Γ REP	ORT			
	R / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION						DATE OF REVISIT	
345106	CATION NUMBER	A. Building B. Wing							10/29/20	019
11 2					12 13					
NAME OF FACILITY TRINITY RIDGE					STREET ADDRESS, CITY, STATE, ZIP CODE 2140 MEDICAL PARK DRIVE					
TRINITI RIDGE					HICKORY, NC 28602					
program, corrected provision	ort is completed by a qual to show those deficienci- d and the date such corre number and the identific by report form).	es previously repo ctive action was a	orted on the accomplished	CMS-2567, State d. Each deficiend	ment of Deficienc y should be fully i	ies and Pla dentified us	n of Corr ing eithe	rection, that have or the regulation o	r LSC	
ITEM		DATE	ITEM		DATE		ITEM			DATE
Y4		Y5	Y4		Y5		Y4			Y5
ID Prefix	F0656	Correction	ID Prefix	F0658	Correct	tion ID	) Prefix	F0761		Correction
Reg.#	483.21(b)(1)	Completed	Reg. #	483.21(b)(3)(i)	Comple	eted R	eg. #	483.45(g)(h)(1)(2)		Completed
LSC		10/13/2019	LSC		10/13/20	019 LS	SC SC			10/13/2019
		_	+			+				
ID Prefix	F0880	Correction	ID Prefix		Correct	tion ID	) Prefix			Correction
Reg.#	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Comple	eted R	eg. #			Completed
LSC		10/13/2019	LSC			LS	SC			
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ID Prefix		Correction	ID Prefix		Correct	tion ID	) Prefix			Correction
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ID Prefix		Correction	ID Prefix		Correct	tion ID	) Prefix			Correction
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LSC		_	LSC				SC			
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Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

**REVIEWED BY** 

STATE AGENCY

REVIEWED BY

CMS RO

9/19/2019

**REVIEWED BY** 

REVIEWED BY

(INITIALS)

(INITIALS)

DATE

DATE

TITLE

SIGNATURE OF SURVEYOR

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

DATE

DATE