## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345153		B. WING	B. WING		08/27/2020		
NAME OF PROVIDER OR SUPPLIER  TRINITY OAKS				STREET ADDRESS, CITY, STA 820 KLUMAC ROAD SALISBURY, NC 28144	TE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	An unannounced COVID-19 Focused Survey was conducted on 8/27/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# G2IE11 INITIAL COMMENTS		F	000			
	Control Survey was of facility was found in constant \$483.80 infection consimplemented the CMS	OVID-19 Focused Infection conducted on 8/27/2020. The compliance with 42 CFR atrol regulations and has S and Centers for Disease on (CDC) recommended for COVID-19.					
E 000	Initial Comments  An unannounced CC was conducted on 8/2 found in compliance related to E-0024 (b)(for Long Term Care FINITIAL COMMENTS  An unannounced CC Control Survey was capacility was found in capacity statements of the CMS Control and Preventice of the CMS control and Pre	2VID-19 Focused Survey 27/2020. The facility was with 42 CFR §483.73 (6), Subpart-B-Requirements facilities. Event ID# G2IE11 2VID-19 Focused Infection conducted on 8/27/2020. The compliance with 42 CFR atrol regulations and has S and Centers for Disease on (CDC) recommended	E	CROSS-REFERENCE DE			ATE

**Electronically Signed** 

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.

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

TITLE

(X6) DATE