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

PRINTED: 02/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345554	B. WING		12/0	5/2012
NAME OF PROVIDER OR SUPPLIER TRINITY GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMP	
F 000 INITIAL COMMENT The facility is in corequirements of 42 Long Term Care Facility Survey). Event ID	ompliance with the CFR Part 483, Subpart B for acilities (General Health	F 00	,		
ADODATORY DIRECTORIO OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATHOE	TITLE		(X6) DATE

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - TRINITY GROVE		(X3) DATE SURVEY COMPLETED	
		345554	B, WING		01/16/2013	
NAME OF P			ο γ	REET ADDRESS, CITY, STATE, ZIP CODE 31 JUNCTION CREEK DRIVE 1 2013 VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(FACH DEFICIENCY MUST BE PRECEDED BY PULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRU (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
	conducted as per at 42 CFR 483.70 section of the LSt publications. This construction, one automatic sprink! The deficiencies are as follows: NFPA 101 LIFE SEXIT access is arr accessible at all 17.1. 18.2.1 This STANDARD Surveyor: 27871 Based on observapproximately 8: ilems were noncinclude: when interprepared include: when interprepared in the mergency released in the sexit accession of the condition of the c	Code(I_SC) survey was The Code of Federal Register D(a); using the New Health Care C and its referenced building is Type III (211) story, with a complete er system. determined during the survey EAFETY CODE STANDARD ranged so that exits are readily times in accordance with section of is not met as evidenced by: ations and staff interview at so am onward, the following compliant, specific findings erviewed staff on where se switch was located for may of thave knowledge of location of tation.	K 038	Exit access will be arranged so are readily accessible at all tim accordance with section 7.1. In order to fully comply with the standard, employees have been educated as to the location and of the maglock emergency relesswitch. In order to identify other life so issues having the potential to a residents by a similar deficient.	his re- function case afoly ffect practice, nos has ion eeting tondance cient ector of all resident on a ct is yee midelines. action to ce will not crform a n each asis, and	
AHORATOR	Y DIRECTOR'S PEPRC	Niderusupplier Representative's Sig	NATURE	Time	(X6) DATE	

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If continuation sheet Page 1 of 1