A. BUILDING _____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345153

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED

R-C

09/03/2019

MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER

TRINITY OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE

820 KLUMAC ROAD

SALISBURY, NC 28144

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)

COMPLETION DATE

ID PREFIX TAG

INITIAL COMMENTS

An in house follow up was completed and the facility was brought back into compliance effective 8/27/19.

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

TITLE

DATE

Electronically Signed

09/04/2019

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.