**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345088

**(X2) MULTIPLE CONSTRUCTION B. WING _____________________________**

**(X3) DATE SURVEY COMPLETED:** 05/20/2020

**NAME OF PROVIDER OR SUPPLIER:**

TRINITY GLEN

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

849 WATERWORKS ROAD

WINSTON-SALEM, NC 27101

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>A Focused Infection Control Survey was conducted on 5/20/20. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID # 312311.</td>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>On May 22, 2020 the facility was provided an amended 2567 survey report. An Administrative Informal Dispute Resolution deleted tag F-880 from the report. As a result no citations were cited during this Focused Infection Control Survey. Event ID #312311.</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

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.