### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
TRINITY VILLAGE

#### Address
1265 21 STREET NE
HICKORY, NC  28601

#### State and Zip Code
345152

#### Provider/Supplier/CLIA Identification Number
07/22/2020

#### Date Survey Completed
08/14/2020

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

<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>
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</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>An unannounced COVID-19 Focused Survey was conducted on 07/22/2020 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# VZJR11.</td>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>An unannounced COVID-19 Focused Infection Control Survey was conducted on 07/22/2020. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# VZJR11.</td>
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**Electronically Signed**

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

08/02/2020

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.