STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________

B. WING _____________________________

(2) MULTIPLE CONSTRUCTION

Provided by CLIA Identification Number:

345088

(0) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED

C 05/23/2022

FORM APPROVED

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

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)

ID
PREFIX
TAG

ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

A onsite follow-up and complaint investigation survey was conducted on 5/23/2022. Event ID# 0CZC11.
The following intakes were investigated: NC00189164.
3 of the 3 complaint allegations were not substantiated.

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.