

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970230	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/09/2025
NAME OF PROVIDER OR SUPPLIER TRINITY COMMUNITY LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 458 N W MARION ST MADISON, FL 32340		
(X4) 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)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revisit to the licensure survey which originally occurred on 7/15/2025 was performed on 10/9/2025 at Trinity Community Living LLC, an Assisted Living Facility in Madison, FL. A biennial relicensure survey was performed concurrent to this visit. Previous deficiencies were cleared at the time of the revisit.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X8) DATE