

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/01/2024
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 230 AIRLINE ROAD COLUMBUS, MS 39702		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS The State Agency (SA) conducted an on-site revisit at the facility on 7/1/2024 related to re-certification survey conducted 5/28/2024 through 5/30/2024. The SA found the facility to be in compliance with the requirements of participation in Medicare and Medicaid and recommends the facility be placed back into compliance effective 6/19/2024. The census at the time of survey was 58 and the facility held a license for 60 beds.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE

07/03/2024