

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44TH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/13/2022
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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #00018342 at the facility on 4/13/2022. During the survey, the SA determined that the facility was in compliance with the requirements of participation for The Aged and Infirm. The SA did not substantiate the complaint for abuse, neglect, or quality of care and cited no deficiencies. The facility has a census of 55 and a bed availability of 60.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/27/22