Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	25D0916400	05/02/2018
Name of Provider or Supplier	**Street Address, City, State**	
Trace Regional Hospital Abg	1002 E Madison St, Houston, MS	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies**
No Tags	No deficiency details available.