

State of GA. Healthcare Facility Regulation Division

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>ALC000706</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                 |   | (X3) DATE SURVEY COMPLETED<br><br><b>08/25/2022</b> |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARBOR AT BRIDGEMILL, THE</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>700 FREEDOM BLVD<br/>CANTON, GA 30114</b> |   |   |
| (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                                  |
| L 000   | <p>Initial Comments.</p> <p>&gt;&gt;&gt;&gt;The purpose of this visit was to conduct a compliance inspection and investigate intakes #GA00225595 and GA00224197.</p> <p>An on-site visit was made on 8/18/22, and was completed on 8/25/22.</p> <p>No rule violations were cited as a result of these investigations and inspection.</p> | L 000   |   |   |

State of GA Inspection Report

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

TITLE

(X6) DATE