State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING NTP001029 06/03/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **592-A MEDICAL PARK DRIVE** LANIER TREATMENT CENTER, INC GAINESVILLE, GA 30501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) Z 000 INITIAL COMMENTS. Z 000 The purpose of this visit was to conduct a compliance inspection. No rule violations were

State of GA Inspection Report

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

TITLE

(X6) DATE

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State of	GA, Healthcare Fac	lity Regulation Division				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NTP001029		NTP001029	B. WING		00/05/0000	
				06/05/2023		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LANIER TREATMENT CENTER, INC 592-A MEDICAL PARK DRIVE GAINESVILLE, GA 30501						
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMPLETE EFERENCED TO THE APPROPRIATE DATE	
Z 000	000 INITIAL COMMENTS.		Z 000		·	
, Allidon,	The purpose of this	visit was to conduct a No rule violations were cited	2 000			

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(X6) DATE