State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NTP001006	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAINBRIDGE TREATMENT CENTER	931 S WEST STREET BAINBRIDGE, GA 39819

(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
Z 000	INITIAL COMMENTS. >>>>The purpose of this visit was to conduct a compliance inspection. No rule violations were cited.	Z 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NTP001006	A. BUILDING: _____ B. WING _____	08/07/2024

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BAINBRIDGE TREATMENT CENTER	931 S WEST STREET BAINBRIDGE, GA 39819

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Z 000	INITIAL COMMENTS. The purpose of this visit was to conduct an annual compliance inspection. No rule violations were cited.	Z 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE