AND PLAN OF	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: NTP001028	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			8. WING		06/07/2023
IAME OF PROVIDER OR SUPPLIER STREET A			ADDRESS, CITY, STATE, ZIP CODE		1 00/07/2023
OBERT W	DAIL MEMORIAL TR		SPITAL ROAD RCE, GA 30529		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMP
Z 000 II	NITIAL COMMENT	S.	Z 000		
С	>>> The purpose of ompliance survey. s a result of this ins	of this visit was to conduct a No rule violations were cited	: :		
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(X6) DATE

TITLE

State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: ___ COMPLETED B. WING_ NTP001028 06/10/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 734 HOSPITAL ROAD ROBERT W DAIL MEMORIAL TREATMENT CEI COMMERCE, GA 30529 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z 000 INITIAL COMMENTS. Z 000 The purpose of this visit was to conduct a compliance inspection. No rule violations were cited. State of GA Inspection Report ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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If continuation sheet 1 of 1