

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009755	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/10/2021
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NAME OF PROVIDER OR SUPPLIER LAKESIDE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NORTH CHESTER AVENUE DOUGLAS, GA 31533
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(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
A 000	Opening Comments. >>>> The purpose of this visit was to conduct a compliance inspection and to investigate intake #GA00211632 and #GA00211142. No rule violations cited as a result of this inspection.	A 000		

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE