State of GA, Healthcare Facility Regulation Division

AND PLAN OF CORRECTION		(XX) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		PCH009158	B. WING		12/13/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DORESS, CHY, ST	Are. ZIP CODE		
LAKES C	ROSSING SENIOR CARE		SS ROAD			
KINGSLAND, GA 31548						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE	
V 000	Opening Comments.		A 000			
	>>>> The purpose of this visit was to investigate intake GA00241568 and conduct a compliance inspection			The submission of this Plan of Correction is an admission that a deficiency exists or that cited correctly.		
	The investigation started on 12/11/2023. The visit to the facility was made on 12/13/2023. The investigation was completed on 12/13/2023.					
A1314 SS=D	111-8-6213(6) Physical Plant Health and Safety Standards. Floors, walls, and ceilings must be kept clean and in good repair.		A1314	A1314		
				1. The community will continue, at minim quarterly carpet cleaning until flooring instant can be completed.	num, 6-1-23 tall :	
				The community will maintain in its post the appropriate floor cleaning equipment.		
	This RULE is not met >>>> Based on obser facility failed to ensure clean. Findings include	vation and interview, the that floors were kept				
	approximately 1:41 p.i memory care unit had	cility on 12/13/2023 at m., the carpet flooring in the discoloration as big as a er various sizes of stains of		PUV		
	the corporate manage	n., Staff B stated the ware of carpet stains, and				
:	on carpet flooring was	ew, Staff A stated this issue discussed in a corporate orate office will take care of				
	During a phone intervi	ew, the corporate director				

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

TITLE

(X6) DATE

State of GA, Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ PCH009158 12/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 GROSS ROAD LAKES CROSSING SENIOR CARE KINGSLAND, GA 31548 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREHIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG RECULATORY OR LSG IDENTIFYING INFORMATION) ľAO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A1314 Continued From page 1 A1314 of operations stated the carpet will be replaced in about four (4) to six (6) weeks. He/she further stated there was no invoice yet for the replacement of the carpet.

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