

State of Georgia, Office of Regulatory Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060-R-0068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2009
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NAME OF PROVIDER OR SUPPLIER MEDSIDE HOME CARE AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 JOHNSON FERRY ROAD SUITE 800 ATLANTA, GA 30342
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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
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L 000	<p>Initial Comments.</p> <p>A periodic licensure survey was completed on February 10, 2009 with no deficiencies cited. At the time of the survey, the agency was in compliance with the Rules and Regulations for PRIVATE HOME CARE PROVIDERS, Chapter 290-5-54.</p>	L 000		
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ORS Inspection Report

TITLE

(X6) DATE

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