

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>033-0330-H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>03/31/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMITY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>161 VILLAGE PARKWAY, BUILDING 7 MARIETTA, GA 30067</b>	
(X4) ID PREFIX TAG	<b>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</b>		
{Z 000}	<p>INITIAL COMMENTS.</p> <p>A Revisit survey was conducted at Amity Care Hospice, Marietta, Georgia, on 3/31/22. The agency was in compliance with Chapter 111-8-37 Rules and Requirements for Home Health and Hospice Agencies. The census was 49.</p> <p>A Revisit survey was conducted at Amity Care Hospice, Marietta, Georgia, on 3/31/22. The agency was in compliance with Chapter 111-8-12.03(h), Criminal Background Checks.</p>		