

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">129030051</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">08/07/2025</p>
NAME OF PROVIDER OR SUPPLIER <p style="text-align: center;">PERFECT CARE</p>		STREET ADDRESS, CITY, STATE, ZIP CODE <p style="text-align: center;">114 SULLIVAN DRIVE AMERICUS, GA 31709</p>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{0000}	Opening Comments. >>>>The purpose of this visit was to conduct a re-licensure. No rule violations were cited as a result of this inspection. An unannounced visit was made on 8/5/2025 at 9:00 a.m. and the inspection was completed on 8/7/2025.		