

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">1-136-2188</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">06/26/2025</p>
NAME OF PROVIDER OR SUPPLIER <p style="text-align: center;">HARBORVIEW THOMASVILLE</p>		STREET ADDRESS, CITY, STATE, ZIP CODE <p style="text-align: center;">930 SOUTH BROAD ST. THOMASVILLE, GA 31792</p>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{N 000}	Initial Comments During a State Licensure survey conducted at Harborview Thomasville on June 24, 2025, through June 26, 2025, to determine compliance with the State Long Term Care Requirements, State Health deficiencies were cited.		