



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075-R-0012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>03/06/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>4 SEASONS HOME CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>119 ROCK QUARRY ROAD STOCKBRIDGE, GA 30281</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
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