STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Wellness Retreat	**45 East Howard Street Kingston, 30145**

(X4) ID PREFIX TAG	**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**
{0000}	Initial Comments Inital Comments >>>>The purpose of this survey was to conduct an initial inspection. It was determined that building (C) office space was not set up as required for a functioning nursing station. Program administration opted to re-purpose this space for scheduled current client assessment until the need changes. Administration was advised to contact the Department upon change. All other concerns were addressed. No rule violations were observed.