

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PHCP012052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER HELP HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 SUMMIT OAKS CT LAWRENCEVILLE, GA 30043	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{L 0000}	Initial Comments. The purpose of this visit was to conduct a periodic compliance survey on December 29, 2025. Rule violations were cited.		
{L 0804} SS= D	111-8-65-.08(2)(a) Inspections and Plans of Correction. Department representatives shall be allowed reasonable and meaningful access to the provider's premises, all records relevant to licensure and all provider staff. Providers shall assist and cooperate in arranging for department representatives to have meaningful access to provider's clients who consent to be interviewed by department representatives in connection with any licensure activity. This REQUIREMENT is not met as evidenced by: Based on an attempt to conduct a periodic licensure survey on December 29, 2025, it was determined that the agency failed to ensure access to the premises, all records relevant to licensure, and to provider staff. Findings were: 1. A telephone call was made to the agency on December 29, 2025, at 10:12 A.M., to inform the provider of the upcoming inspection. The administrator		

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	stated that there is no staff available to be present for the survey. As a result, the survey was aborted, and Healthcare Facility Regulation Division Private Home Care Unit was notified.		