

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060-141	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/03/2013
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NAME OF PROVIDER OR SUPPLIER SUMMIT MEDICAL ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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U 000	<p>INITIAL COMMENTS</p> <p>At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation #GA00119494.</p>	U 000		
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State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____