STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 000	Initial Comments On March 19, 2026, an unannounced licensure survey was conducted for this 28 bed Assisted Living Facility with a census of 18. One complaint was investigated during this survey. LC#20220919016 was unsubstantiated. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF). The deficiencies cited pose a potential risk of harm to the residents and require a plan of correction. Amended July 21, 2026 to remove Resident Identifier (RI)#4 information from citation 604.	A 000		
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities.	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 405	Continued From page 1 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire.	A 405	1) **420-5-4-.04 (6) Personnel** **Failure to ensure all staff members were trained in the special needs of a resident, specifically regarding the care and monitoring of a resident utilizing Continuous Glucose Monitoring (CGM) for the management of Diabetes Mellitus, in accordance with Alabama Department of Public Health (ADPH) code requirements.** 2) Upon identification of the deficiency, the facility conducted a review of employee training records to verify staff education related to diabetes management and Continuous Glucose Monitoring (CGM). Documentation was located verifying that an in-service on Diabetes Mellitus Management, including Continuous Glucose Monitor (CGM) care, maintenance, and monitoring, was provided to caregivers on **May 16, 2025**. This documentation has been retained in the facility's training records. To ensure all current employees have received this education, an additional mandatory in-service covering Diabetes Mellitus management and Continuous Glucose Monitoring (CGM) care and maintenance has been completed as of **July 15, 2026**. All direct care staff have completed the training. 3) **03-18-25** A review of all Residents with special needs was conducted by the Residence Nurse. No other deficiencies were identified that relate to this citation. 4) The upcoming mandatory in-service will include, at a minimum: • Overview of Diabetes Mellitus. • Recognition of signs and symptoms of hypoand hyperglycemia. • Continuous Glucose Monitoring (CGM) operation and purpose. • Routine CGM care and maintenance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 405	Continued From page 2 An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization. (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to train all staff members in special needs of a resident. Findings: Review of personnel records on March 18, 2026, revealed Employee Identifier (EI)#1, EI#2, EI#3, EI#4, EI#5, EI#6 and EI#7 did not have documentation of training in continuous glucose monitoring. The facility currently had one resident with a diagnosis of diabetes mellitus with glucose levels monitored continuously. EI#1 acknowledged the required training in special needs had not been completed. EI#1 said she	A 405	Responding Appropriately to CGM Alerts Documentation Requirements Resident-specific physician orders. When to notify the licensed nurse or physician. Facility policies and procedures regarding specialized resident care. Attendance and competency documentation will be maintained for all employees. 5) The Administrator and Resident Nurse will review training records monthly for a minimum of one (1) year to verify that all employees have completed required resident-specific education before providing care. Whenever a resident with specialized care needs is admitted or develops a new condition requiring additional staff education, the Administrator and Resident Nurse will ensure training is completed and documented before staff members provide care. Training records will be maintained in the Administrator's office. The Regional Manager will review compliance during monthly visits for a minimum of one (1) year to verify ongoing compliance with ADPH requirements. Any deficiencies identified will be corrected immediately through additional education, competency validation, and follow-up monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 405	Continued From page 3 was not aware that staff had to be trained on the special need of continuous glucose monitoring since the resident self manages the device.	A 405		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 604	Continued From page 4 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, residents were not assessed monthly as required. Findings: Review of residents' facility records, on February March 17 and 18, 2026 revealed: RI#1 RI#1 had resided at the facility since January 29, 2024 and had diagnoses of hypertension, chronic kidney disease, atrial fibrillation, thoracic aneurysm and chronic obstructive pulmonary disease. Monthly assessments were not completed for RI#1 in June 2025, July 2025 and August 2025. RI#2 RI#2 had resided at the facility since May 31, 2022 and had diagnoses of diabetes mellitus II, hypertension and vision loss. Monthly assessments were not completed for RI#2 in June 2025, July 2025 and August 2025. RI#3 RI#3 had resided at the facility since June 1, 2022 and had diagnoses of diabetes mellitus II,	A 604	**1) 420-5-4-.06 (3) (a) (b) Care of Residents Failure to complete monthly assessments as required by ADPH regulations** 2) **03-18-26** Upon identification of the deficiency, the Resident Nurse immediately reviewed the applicable Alabama Assisted Living regulations. The Resident Nurse received education regarding ADPH requirements for monthly resident assessments, including documentation standards, required time frames, and the importance of using assessments to identify changes in resident condition and update service plans as needed. **06-30-26** All monthly assessment have been completed from November 2025 - June 2026 3) **03-18-26** The Resident Nurse completed the required monthly assessments for the residents identified during the survey and corrected any deficiencies noted. In addition, a comprehensive review of all resident monthly assessments was conducted to verify that each resident's assessment was current, complete, and accurately reflected the resident's condition and care needs. Any missing or incomplete assessments identified during this review were completed immediately. 4) The facility has implemented a monthly assessment tracking system to ensure each resident receives a timely monthly assessment in accordance with ADPH requirements. The Resident Nurse will maintain a monthly assessment schedule that identifies the due date for each resident's assessment. Assessments will be completed monthly and reviewed for accuracy and completeness prior to being filed in the resident's medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 604	Continued From page 5 hypertension, chronic kidney disease and mild cognitive impairment. Monthly assessments were not completed for RI#3 in June 2025, July 2025 and August 2025. On the afternoon of March 18, 2026, EI#1 was asked why monthly assessments had not been completed in June 2025, July 2025 and August 2025. EI#1 responded that there was no nurse.	A 604	The Administrator will review the monthly assessment tracking log for a minimum of one (1) year to verify all required assessments have been completed within the required time frame. 5) The Resident Nurse will complete monthly assessments for all residents as required and maintain a tracking log documenting completion. The Administrator will conduct monthly audits of resident records for a minimum of one (1) year to verify that all required monthly assessments have been completed accurately and on time. Audit documentation will be maintained in the Administrator's office.	
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 611	Continued From page 6 current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 611	Continued From page 7 clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record review and interview, residents' facility care plans were not current and did not contain appropriate interventions to meet the care and safety needs of the residents. Findings: Review of residents' facility care plans, on March 17 and 18, 2026, revealed the following information. RI#1 RI#1 had resided at the facility since January 29, 2024. RI#1 was receiving Eliquis 5 milligrams (MG) twice daily. RI#1's care plan did not address the Eliquis with interventions or expected outcomes to guide staff care for RI#1.	A 611	**1) 420-5-4.06 (4) (a) (b) Care of Residents Failure to ensure resident service plans (care plans) were current and contained appropriate interventions to meet the care and safety needs of each resident, in accordance with Alabama Department of Public Health (ADPH) regulations.** 2) **03-25-26** The Resident Nurse and applicable direct care staff received education during the monthly in-service meeting regarding ADPH requirements for resident service plans, emphasizing the importance of maintaining individualized, current care plans that accurately reflect physician diagnoses, assessments, resident preferences, identified risks, and interventions necessary to meet each resident's care and safety needs. Education also included the requirement to promptly revise service plans whenever there is a change in a resident's condition, physician orders, or level of assistance required. **4-10-26** comprehensive review of all resident's orders completed with addendum plan of care completed for any resident on ALL types of blood thinner. 3) **03-18-26** Immediately following identification of the deficiency, the Resident Nurse conducted a comprehensive review of the service plans for all residents identified during the survey. Each resident's physician orders, diagnoses, assessments, medication profile, functional status, and identified care and safety needs were reviewed to ensure the service plan accurately reflected the resident's current condition.	

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D0222	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF FOLEY	615 E LAUREL AVENUE FOLEY, AL 36536

(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
A 611	Continued From page 8 RI#2 RI#2 had resided at the facility since June 1, 2022. RI#2 was admitted with vision loss. RI#2's care plan did not address the vision loss with interventions or expected outcomes to guide staff care for RI#2. On the afternoon of March 18, 2026, EI#1 acknowledged the Eliquis and vision loss should be care planned. THERESA HARRISON, REGISTERED NURSE	A 611	All identified deficiencies were corrected, and the affected resident service plans were updated to include appropriate, individualized interventions necessary to address each resident's care needs, safety risks, and physician-directed services. Additionally, the Resident Nurse completed a comprehensive audit of all resident service plans within the facility to verify they were current, individualized, and contained appropriate interventions. Any discrepancies identified during the audit were corrected immediately. 4) The facility has issued a standardized process requiring resident services plans to be reviewed and updated : • Upon Admission • Following any significant change in condition. • Following hospitalization or return from another healthcare setting. • Upon receipt of new physician orders or diagnoses. • At least quarterly, and more frequently as resident needs change. The Resident Nurse is responsible for ensuring service plans accurately reflect each resident's current care needs and include appropriate interventions to promote resident health and safety. The Administrator will verify completion of all required reviews. 5) The Resident Nurse will conduct monthly audits for a minimum of one (1) year of resident service plans to verify they remain current, accurate, and include appropriate interventions to address each residents care and safety needs. The Administrator will review audit findings monthly for minimum of one (1) year and maintain documentation in the Administrator's office. The Regional Manager will review service plan audits during monthly compliance visits for a minimum of one (1) year to ensure continue compliance with ADPH requirements. Any deficiencies identified through the audit process will be corrected immediately, with additional staff education, service plan revisions, and follow-up monitoring implemented as necessary to ensure sustained compliance. **All documentation pertaining to Audits, Monthly Reviews, Inspections, etc will be maintained in the office of the Administrator.**	