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
	D2705	A. BUILDING: _____ B. WING _____	C 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF BREWTON	905 BELLEVIEW AVENUE BREWTON, AL 36426

(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 25, 2026, an unannounced licensure survey was conducted for this 28 bed Assisted Living Facility (ALF) with a census of 23. There were three complaints investigated during this survey. LC#20260316002 and LC#20250924004 were substantiated and deficiencies were cited as a result of these complaint investigations. LC#20230123015 was unsubstantiated but one deficiency was cited as a result of the investigation of the complaint. 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. The deficiencies cited pose a risk of harm to the residents and require a plan of correction.	A 000		
A 301	420-5-4-.03 (1) (a) (b) (c) (d) Administration. The Assisted Living Facility Governing Authority. (a) An assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an	A 301		

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A 301	Continued From page 1 ownership interest of 10 percent or more in the real property or building used by the assisted living facility to offer its services. 3. Each officer and each director of the corporation if the governing authority is a corporation. 4. Each partner, including any limited partners, if the governing authority is a partnership. (b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change. (c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder. (d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the governing authority failed to ensure the facility operated in compliance with the SBOH	A 301	1) 420-5-4-.03 (1) (a) (b) (c) (d) Administration (A Governing Authority will ensure the facility is managed responsibly and in compliance with the SBOH Rules for ALF's.	

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A 301	Continued From page 2 rules for ALFs. The governing authority's lack of adequate oversight resulted in repeat deficient practices which placed all 23 residents of the facility at risk for harm due to this failure to apply the SBOH rules for the day to day operations of the facility. Findings: Employee Identifier (EI)#11, the Director of Operations, was interviewed regarding the repeat citations. EI#11 was asked what oversight was provided after the the July 17, 2024, survey. EI#11 answered onsite visits every three months. EI#11 said her visits, weekly phone meetings, task reminders of what needed to be done and email reminders were put in place to deter repeat deficiencies. EI#11 said she as the Director of Operations, was to provide oversight. EI#11 was asked what she did with the documentation that, according to the plan of correction, was sent to her monthly. EI#11 said she reviewed it. EI#11 was asked what documentation she had to support she made the three monthly visits to the facility and quarterly visits afterward. EI#11 said she had her travel documentation. EI#11 said she did not know why there were repeat deficiencies from the July 17, 2024, survey. NOTE: Six deficiencies were cited that were repeated from the July 17, 2024, survey. Therefore, the plan of correction submitted by the facility was not implemented and maintained. The following deficient practices were cited during the onsite survey due to a lack of management and oversight of the facility by the governing authority. 302 - The facility failed to follow it's own policies. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024.	A 301	In-Service and training were provided to EI#1 by the Director of Operations, with a focus given to following facility policy and procedures; understanding and maintaining all required Plans of Correction; ensuring all corrective actions are implemented, monitored, and sustained; employee training prior to resident contact; development, review, and updating resident service plans/ care plans to reflect appropriate interventions. Documentation of this training will be maintained in the Administrator's office. Effective immediately, the Governing Authority has implemented the following corrective measures: The Executive Director, along with the Director of Operations and the Governing Authority, have conducted a comprehensive review of every deficiency cited during the current survey, including all deficiencies identified as repeat citations. The Governing Authority assigned each deficiency a corrective action plan with designated responsible parties, required completion dates, and measurable outcomes. Comprehensive Regulatory Audit Forms have been developed and put into place to ensure compliance in all areas. The Regional Manager will conduct monthly onsite visits for a minimum of one (1) year rather than quarterly visits. After one (1) year period, onsite visits may return to quarterly visits schedule only if documentation demonstrates sustained compliance. Monthly compliance reports will be submitted to the Governing Authority for a period of one (1) year. The Governing Authority will review all monthly compliance reports and audit any findings to ensure deficiencies are corrected promptly and remain corrected. Documentation of this will be maintained in the Administrator's office.	

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A 301	Continued From page 3 303 - The former facility administrator failed to ensure the Plan of Correction was implemented and maintained. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 405 - Training was not provided prior to resident contact. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 504 - The plan of correction from the previous suvey conducted July 17, 2024, was not posted. 602 - Residents' medical examination was incomplete or incorrect. 611 - Residents' care plans were not current and did not contain appropriate interventions to address the care needs of the resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 612 - The facility failed to have an activity program designed to meet the needs of each resident. 614 - Residents were not given the opportunity to utilize the unit dose packaging system. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 702 - The facility failed to: 1) ensure food items were stored in a manner to protect them from potential contamination. 2) to ensure the only sink in the kitchen had soap and paper towels for hand hygiene 3) to have documentation logs demonstrating that the facility was monitoring for proper food storage temperatures and 4) the food temperature logs had not been completed since March 1, 2026. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 703 - The facility failed to post the current weekly menu in the food service area. 1203 - The facility failed to provide a functional call system for each resident.	A 301		

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A 302	Continued From page 4	A 302		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing.	A 302		

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A 302	Continued From page 5 (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks,	A 302		

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A 302	Continued From page 6 and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow it's own policies. Findings: According to the facility's Medical Exam (Examination) & Service Plan policy, "... 2. The Medical Exam & Service Plan shall include the following documentation: a. All of the physician's diagnoses. ..." Refer to deficiency 602 for	A 302	420-5-4-.03 (1) (e) Administration (A 302) Administrator will ensure that all facility staff have been properly trained on facility Policy and Procedures upon hiring and are trained monthly, and all training remains current and in accordance with Alabama Department of Public Health Requirements for ALF's.	

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A 302	Continued From page 7 additional information. According to the facility's Food Service Sanitation policy, "... POLICY: To ensure that this facility appropriately ... follows appropriate sanitary food preparation and handling techniques. 5. ... A record for each test shall be maintained ... 10. Keep cabinet shelves neat and clean. 14. ... Kitchen trash and garbage shall be placed in suitable containers ..." Refer to deficiency 702 for additional information.	A 302	Failure to maintain compliance with the previously accepted Plan of Correction (July 2024), resulting in repeat deficiencies related to policy and procedure implementation. The Administrator has provided education to all department heads and applicable staff regarding the facility's policies and procedures. Staff was instructed on the importance of following established facility policies and maintaining compliance with the Alabama Assisted Living Rules and Regulations. Documentation on all training has been maintained in employee education records. To ensure ongoing compliance, all newly hired employees will receive training on policies and procedures during orientation before providing resident care. Existing staff will receive annual education on facility policies and procedures, as well as additional training whenever policies are revised, new regulations are implemented, or compliance concerns are identified. The Administrator or designee will conduct monthly compliance audits of facility policies and procedures for a minimum of one (1) year following implementation of this Plan of Correction. The Regional Manager will review these policy and procedure audits monthly to verify ongoing compliance, the effectiveness of corrective actions, and continued implementation of the Plan of Correction. All audit documentation will be maintained in the Administrator's office. Any policy and procedure deficiencies identified will be addressed immediately through education, counseling, process improvement, or disciplinary action, as appropriate. Audit findings and identified trends will be reviewed during monthly meetings between the Administrator and Regional Manager to ensure sustained compliance and prevent recurrence of deficiencies.	
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.	A 303		

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A 303	Continued From page 8 6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and	A 303		

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A 303	Continued From page 9 appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the former administrator failed to ensure the plan of correction from the July 17, 2024, survey was implemented. Findings: The following deficiencies were repeated from the July 17, 2024, survey: 303 - The former facility administrator failed to ensure the Plan of Correction was implemented and maintained. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 405 - Training was not provided prior to resident contact. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 611 - Residents' care plans were not current and did not contain appropriate interventions to address the care needs of the resident. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 614 - Residents were not given the opportunity to utilize the unit dose packaging system. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. 702 - The facility failed to: 1) ensure food items were stored in a manner to protect them from	A 303	420-5-4-.03 (2) (a) Administration (A 303) The facility failed to ensure the previously submitted Plan of Correction from the July 17, 2024, survey was fully implemented and maintained, resulting in repeat deficiencies identified during the March 2026 survey. The Administrator will ensure that the facility follows all Plans of Correction in accordance with Alabama Department of Public Health Requirements for ALF's	

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A 303	Continued From page 10 potential contamination. 2) to ensure the only sink in the kitchen had soap and paper towels for hand hygiene 3) to have documentation logs demonstrating that the facility was monitoring for proper food storage temperatures and 4) the food temperature logs had not been completed since March 1, 2026. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 17, 2024. On the morning of March 25, 2026, EI#1, the Administrator, agreed these were repeat deficiencies and they would be corrected.	A 303	The Administrator responsible for failing to implement and sustain the previous Plan of Correction is no longer employed by the facility. A new Administrator assumed responsibility for the community on March 16, 2026, prior to the current survey. Immediately following the March 2026 survey, the current Administrator conducted a comprehensive review of all deficiencies cited during the July 17, 2024, survey. All cited areas were evaluated for compliance. Resident records, employee training records, medication management practices, dietary services, infection prevention practices, environmental safety, and facility policies and procedures were reviewed to ensure compliance with Alabama Assisted Living Administrative Rules and facility policies. Any deficiencies identified during these reviews were corrected immediately.	
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. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the	A 405	To ensure ongoing compliance, the Governing Authority has implemented the following corrective measures: The Executive Director, along with the Director of Operations and the Governing Authority, have conducted a comprehensive review of every deficiency cited during the current survey, including all deficiencies identified as repeat citations. The Governing Authority assigned each deficiency a corrective action plan with designated responsible parties, required completion dates, and measurable outcomes. Comprehensive Regulatory Audit Forms have been developed and put into place to ensure compliance in all areas. The Regional Manager will conduct monthly onsite visits for a minimum of one (1) year rather than quarterly visits.	

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A 405	Continued From page 11 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. 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	A 405	After one (1) year period, onsite visits may return to a quarterly visit schedule only if documentation demonstrates sustained compliance. Monthly compliance reports will be submitted to the Governing Authority for a period of one (1) year. The Governing Authority will review all monthly compliance reports and audit any findings to ensure deficiencies are corrected promptly and remain corrected. Documentation of this will be maintained in the Administrator's office.	

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A 405	Continued From page 12 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 review and interview, the facility failed to train a caregiver prior to resident contact. Findings: Review of employee files on March 24, 2026 revealed EI#8, a former caregiver, did not receive training prior to resident contact. On the afternoon of March 24, 2026, EI#8 reported she was not trained prior to resident contact. Later that afternoon, EI#1 agreed staff should be trained prior to resident contact.	A 405	420-5-4-.04 (6) Personnel (A 405) The facility failed to ensure that caregivers received required training prior to having contact with residents in accordance with facility policy and Alabama Administrative Code. Based on record review and interview, it was identified that a former caregiver did not receive required training before providing care or services to residents. The facility failed to follow its established training and orientation procedures to ensure employees completed required training prior to resident contact. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility. Administrator will ensure that all facility staff have been properly trained upon hiring and before resident contact, are trained monthly, and all training remains current and in accordance with Alabama Department of Public Health Requirements for ALF's.	
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident	A 405		

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A 504	Continued From page 13 common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.	A 504	2) Effective **07/02/26**, following receipt of the survey findings, the Director of Operations conducted a Teams training with the Administrator and Residence Nurse to address completion of all required employee training prior to any resident contact. Documentation of these in-services will be maintained in the Administrator's office. 3) 3-27-26 Administrator completed an audit of training files to identify any other concerns not identified during the survey. No other deficiencies were found. 4) To ensure continued compliance, the following systems have been implemented: **04-03-26** • A Pre-Resident Contact Training Verification Form has been developed to document that all required orientation and training requirements have been successfully completed before any employee is permitted to provide resident care. • Comprehensive Annual Employee Training Checklists have been developed to monitor required education throughout each employee's employment. • Individual State Survey Compliance Folders have been established for every employee to maintain all required training records, certifications, and other regulatory documentation in one organized location.	

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A 504	Continued From page 14 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer	A 504	5) To ensure long-term compliance and prevent recurrence: • All corrective actions will be documented and maintained in the Administrator's office. • The Administrator will conduct routine compliance audits for a minimum of one (1) year to verify adherence to employee training requirements. • Any deficiencies identified during these audits will be addressed immediately through re-education, corrective counseling when appropriate, and additional monitoring until sustained compliance is demonstrated.	

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A 504	Continued From page 15 meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care.	A 504		

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A 504	Continued From page 16 (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent	A 504		

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A 504	Continued From page 17 inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.	A 504		

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A 504	Continued From page 18 This Rule is not met as evidenced by: Based on observation and interview the previous survey results were not posted. Findings: On the evening of March 23, 2026, an observation was made for required postings with EI#2, the Licensed Practical Nurse (LPN). The previous state inspection Plan of Correction report was not posted. During this observation EI#2 acknowledged the Plan of Correction should have been posted.	A 504	1) 420-5-4-.05 (3) (d) Records and Reports (A 504) The facility failed to ensure the results of the previous state survey, including the Plan of Correction, were posted in accordance with Alabama Department of Public Health (ADPH) requirements. Based on observation and interview, the previous state survey Plan of Correction was not posted as required. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility, as well as their family members, responsible parties, prospective residents, and other individuals entitled to review the posted survey information. The Administrator will ensure that the current Plan of Correction is posted in accordance with Alabama Department of Public Health Requirements for ALF's 2) The deficiency was corrected immediately. On March 26, 2026, the facility posted the previous survey results and Plan of Correction in the designated public area where they are readily accessible to residents, families, visitors, and the public, as required by ADPH regulations. 3) After an review completed by the Administrator on March 26, 2026, no other concerns were identified that are related to this citation. 4) The Administrator has implemented a regulatory compliance checklist to ensure all required postings, including survey results and Plans of Correction, are displayed promptly following receipt and remain posted for the time frame required by state regulations.	
A 602	420-5-4-.06 (2) (a) (b) (c) Care of Residents. (2) Medical Examination Record. (a) Initial Physical Examination. Not more than 30 days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination only, a currently licensed physician in good standing with the Medical Licensure Commission of any state may complete this physical assessment. The physician shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician recommends or believes is pertinent, the initial physical examination record shall contain the following: 1. All of the physician's diagnoses, and the resident's baseline weight and vital signs.	A 602		

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A 602	Continued From page 19 2. Medication presently prescribed (name, dosage, and strength of drug, frequency, and route of administration). 3. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact. 4. Documentation of evaluation for tuberculosis within the previous 12 months. (b) Annual Physical Examination. In addition to the admission physical examination, each resident shall be examined annually by a physician, and findings from the annual physical examination shall be documented with a copy placed in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's attending physician, the annual physical examination shall contain the following: 1. The resident's weight and vital signs. 2. Changes in diagnoses. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. (c) Change of Condition Physician Examinations. Changes in the resident's condition that require a physician examination	A 602	5) The Administrator will verify monthly for a minimum of one (1) year that all required regulatory postings remain current and properly displayed. The Regional Manager will review the posting compliance checklist during monthly compliance visits for a minimum of one (1) year to ensure continued adherence to ADPH requirements. Any deficiencies identified will be corrected immediately, with additional education provided as necessary. Documentation of these monthly audits will be maintained in the Administrator's office.	

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A 602	Continued From page 20 and result in a change in diagnoses, medications, or treatments shall be reported to the facility and documented in the resident's medical examination record. In addition to any other items specified in the facility's policies and procedures, and in addition to any information deemed necessary, pertinent, or recommended by the resident's treating physician, this physical examination shall contain a listing of the following: 1. New diagnoses. 2. Changes in condition. 3. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration). 4. Changes in treatment. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician's medical examinations were completed accurately and included all required information. Findings: Review of resident medical records on the morning of March 24, 2026, revealed: Resident Identifier (RI)#3 was admitted to the facility on February 24, 2021. The annual medical examination dated August 22, 2025, listed, "All Diagnosis: No new diagnoses" and the respiration rate as "95". This rendered the medical examination both incomplete and inaccurate.	A 602	1) 420-5-4-.06 (2) (a) (b) (c) Care of Residents (A6012) The facility failed to ensure physician medical examinations were completed accurately and contained all information required by Alabama Department of Public Health regulations. Specifically, physician medical examinations contained inaccurate and incomplete information, including missing diagnoses and incorrect respiratory rates. This deficient practice affected two (2) residents reviewed and had the potential to affect all twenty-three (23) residents residing in the facility who require accurate and complete medical examination records to ensure appropriate assessment, care planning, and continuity of care. The Administrator, along with the Residence Nurse, will ensure that all physician medical examinations are complete and contain all current and accurate information in accordance with Alabama Department of Public Health Requirements for ALF's. 2) **04-08-26** The Administrator and nursing staff reviewed regulations regarding requirements for physician medical examinations, including required documentation, accuracy, and completeness. Management staff were re-educated that incomplete medical examination forms were not be accepted into the resident record until all required information has been obtained. 3) **04-08-26** The facility immediately conducted a review of all resident physician medical examination forms to ensure they were complete, accurate, and contained all required information. Any incomplete or missing information was identified, and the appropriate physician was contacted to obtain the necessary documentation and corrections.	

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A 602	Continued From page 21 RI#4 was admitted to the facility on October 1, 2021, with diagnoses to include iron deficiency anemia, anxiety disorder, insomnia, hypertension and osteoporosis. RI#4's annual medical examination dated August 14, 2025, revealed a respiration rate of 94. On the afternoon of March 24, 2026, EI#1 and EI#2 agreed the medical examination records were not accurate and RI#3's diagnoses should have been listed.	A 602	4) To ensure future compliance, the facility has implemented a two-step review process on 07-02-26 for all physician medical examinations. Upon receipt of a completed medical examination, the licensed nurse will review the document for completeness and accuracy, verifying that all required sections have been completed. Following the nursing review, the Administrator will complete a secondary review. Both the nurse and the Administrator will sign and date the back of each medical examination form to document that the review has been completed and that the form meets ADPH requirements before it is filed in the resident's medical record.	
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	A 611	5) The Administrator and licensed nurse will continue to review and sign all newly received physician medical examinations prior to filing them in the resident's chart. In addition, the Administrator will conduct monthly audits for a minimum of one (1) year of resident medical records to verify physician medical examinations remain complete, accurate, and compliant with ADPH requirements. Audit documentation will be maintained in the Administrator's office. The Regional Manager will review audit findings and compliance documentation during monthly visits for a minimum of one (1) year. Any deficiencies identified will be corrected immediately through follow-up with the physician, staff re-education, and additional monitoring as needed to ensure sustained compliance.	

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A 611	Continued From page 22 dated. 1. The plan shall at all times reflect the 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	A 611		

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A 611	Continued From page 23 prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept 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 24 - 25, 2026, revealed the following information. RI#2 RI#2 had resided at the facility since February 12, 2026. RI#2 was admitted with a visual deficit and required large magnifying glasses to read. RI#2's facility care plan did not address the visual deficit	A 611	**1) 420-5-4-.06 (4) (a) (b) (c) Care of Residents** **(A 611)** **The facility failed to ensure resident care plans were current, accurate, and contained individualized interventions to meet each resident's assessed care and safety needs. Specifically, resident care plans did not accurately reflect identified visual impairments, required assistive devices, and physician-ordered assistance with activities of daily living. This deficient practice affected two (2) of the residents reviewed and had the potential to affect all twenty-three (23) residents residing in the facility by increasing the risk that care needs may not be consistently identified, communicated, or provided in accordance with each resident's assessed needs and physician recommendations. The Administrator, along with the Residence Nurse, will ensure resident care plans are current, accurate, and contain individualized interventions to meet each resident's assessed care and safety needs in accordance with Alabama Department of Public Health Requirements for ALF's.** **2) 04-22-26 The Resident Nurse and applicable staff reviewed regulations regarding ADPH requirements for resident service plans, emphasizing the importance of maintaining current, individualized care plans that accurately reflect physician diagnoses, resident assessments, care needs, and safety interventions. Education also included timely documentation of changes in condition and updating service plans whenever resident needs change.**	

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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
A 611	Continued From page 24 or use of magnifying glasses. RI#3 Refer to citation 602 for additional information regarding RI#3. RI#3's medical examination completed by the physician, indicated RI#3 "Requires physical assist with ADLs (Activities of Daily Living) ADLs are ... Bathing ..." RI#3's facility care plan indicated, "... bathes independantly ..." On the morning of March 25, 2026, EI#1 agreed the facility care plans should be developed to address resident specific needs.	A 611	**3) The facility immediately conducted a comprehensive review of all resident service plans. The Resident Nurse reviewed each resident's medical record, physician orders, diagnoses, assessments, and current care needs to ensure service plans accurately reflected the resident's condition and included appropriate interventions to address identified care and safety needs.** **All resident service plans have been reviewed, updated, and revised by the Resident Nurse to ensure they are current, individualized, and accurately reflect each resident's care requirements and necessary safety interventions.** **4) The facility has implemented a standardized review process requiring service plans to be reviewed:** • **Upon admission.** • **Following any significant change in the resident's condition or physician orders.** • **After hospitalization or return from a healthcare setting.** • **At least quarterly, and more frequently as needed.** **The Resident Nurse is responsible for ensuring all revisions are completed promptly and accurately. The Administrator will verify that required reviews have been completed and appropriately documented.** **5) The Resident Nurse will conduct monthly audits of resident service plans for a minimum of one (1) year to verify they remain current, complete, and include appropriate interventions to meet each resident's care and safety needs.**	
A 612	420-5-4-.06 (4) (c) (d) (e) (f) Care of Residents (c) The facility shall offer appropriate activity programs to each resident, maintaining supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to each resident. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to	A 612		

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A 612	Continued From page 25 regular postal channels upon receipt from the resident. Residents shall be permitted to place and receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to have an activity program designed to meet the needs of each resident. Findings: During a tour of the facility, on March 24, 2026, the surveyor observed a monthly calendar of activities for the facility residents. The activity calendar which showed two scheduled activities daily to include coffee sip and chat. EI#3, the activities director, acknowledged coffee sip and chat was not an activity. EI#3 also said three to four activities were not offered on Saturday and Sunday. Review of the folder provided to new residents indicated three to four activities would be offered daily. On the morning of March 25, 2026, EI#1 acknowledged the activity calendar did not offer three to four activities on Saturday and Sunday. EI#1 also said residents can drink coffee any time of day.	A 612	The Administrator will review audit results monthly for a minimum of one (1) year and maintain documentation in the Administrator's office. The Regional Manager will review compliance documentation during monthly visits for a minimum of one (1) year to ensure continued compliance. Any deficiencies identified will be corrected immediately through service plan revisions, staff re-education, and additional monitoring until sustained compliance is achieved. 1) 420-5-4-.06 (4) (c) (d) (e) (f) Care of Residents (A612) The facility failed to ensure its activity program was designed and implemented to meet the individualized needs and interests of each resident in accordance with facility policy and Alabama Administrative Code. Specifically, the activity schedule did not consistently provide the number and variety of activities represented by the facility, and scheduled activities did not always constitute meaningful resident programming. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility by limiting opportunities for socialization, cognitive stimulation, physical engagement, and activities that support residents' individual interests and overall quality of life. The Administrator will ensure that the Activity Program meets the individualized needs and interests of each resident in accordance with facility policy and Alabama Administrative Code, and that all scheduled activities constitute meaningful resident programming. 2) The facility has taken immediate action to improve the quality and consistency of its resident activity program. A new Activity Director was hired on May 11, 2026, to oversee the planning, implementation, and evaluation of a comprehensive activity program that promotes each resident's physical, cognitive, emotional, social, and spiritual well-being.	

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A 614	420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents. (f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and safety. (g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided: 1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use. (6) Assistance with self-administration of medication includes the following practices: (a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in	A 614	3) The new Activity Director has reviewed resident assessments, preferences, interests, and abilities to develop individualized programming designed to encourage meaningful engagement and participation for all residents. 4) The Activity Director will maintain a monthly activity calendar that offers a variety of group and individualized activities addressing residents' interests, cognitive levels, physical abilities, and personal preferences. 5) The Administrator will review monthly activity calendars for a minimum of one (1) year to verify that programming continues to meet the needs and interests of the resident population. The Regional Manager will review the activity program during monthly compliance visits for a minimum of one (1) year, including observation of activities, activity calendars, and discussions with the Activity Director to ensure continued compliance with ADPH requirements. Any opportunities for improvement identified during these reviews will be addressed promptly through additional education, coaching, and program modifications.	

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A 614	Continued From page 27 relation to mealtimes or other activities such as arising from bed or retiring to bed. (b) Physically assisting a resident by opening or helping to open a container holding medications. (c) Offering liquids to a resident to assist that resident in ingesting oral medications. (d) Physically bringing a container of medication to a resident. (7) Assistance with self-administration of medications shall under no circumstances include any of the following practices: (a) Medication administration as defined in these rules. (b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given. (c) Giving a resident injections of any kind. (d) Telling or reminding a resident that it is time to take a PRN, or as needed medication. (e) Placing medications in a feeding tube.	A 614		

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A 614	Continued From page 28 (f) Giving enemas or suppositories. (g) Crushing or splitting medications, provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. (i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers,	A 614		

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A 614	Continued From page 29 nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff. This Rule is not met as evidenced by: Based on record reviews and interviews, residents were not given the opportunity to utilize the unit dose package system and protect themselves from a medication error. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On March 16, 2026, the ADPH received an anonymous complaint alleging medications were not given correctly. Residents were not given the opportunity to utilize the unit dose package system: Residents were interviewed and asked if they were given the opportunity to identify their medications when staff assisted them. RI#1 said not always.	A 614	**1) 420-5-4-.06 (5) (f) (g) (6)(7) (a)-(i) Care of Residents (A 614)** The facility failed to ensure residents were provided the opportunity to utilize the unit-dose medication packaging system to identify their medications prior to assistance with medication administration, thereby reducing their ability to protect themselves from medication errors. Specifically, staff were observed and acknowledged assisting residents by placing medications into medication cups before presenting them to residents, contrary to facility policy and Alabama Administrative Code requirements. This deficient practice affected two (2) residents interviewed and had the potential to affect all twenty-three (23) residents residing in the facility who receive medication assistance, increasing the risk of medication errors and compromising residents' ability to participate in the medication administration process. The Administrator, along with the Residence Nurse, will ensure that all residents will be allowed to utilize the unit dose packaging system to identify their medications prior to assistance with medication administration. 2) All medication administration staff received comprehensive in-service education on March 31, 2026; April 22, 2026; May 27, 2026; and June 11, 2026. Training included: • Compliance with the facility's medication administration policies and procedures. • Proper medication administration techniques. The purpose and benefits of the unit-dose • medication packaging system in reducing medication errors. • Resident rights regarding medication administration. • Documentation requirements and medication safety practices. • Reporting and prevention of medication errors Attendance documentation for each training session is maintained in the Administrator's office.	

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A 614	Continued From page 30 RI#4 said, "They bring them in a cup." EI#4, a caregiver, was interviewed on the morning of March 25, 2026. EI#4 acknowledged she had taken pills to the residents in a cup after supper. EI#4 claimed this was how EI#9, the former administrator, trained her to assist with medications. EI#4 said an interim administrator had told them they were doing it incorrectly, but noone had ever trained them the correct way. On the morning of March 25, 2026, EI#1 agreed staff should not take a cup of pills to resident without giving those residents the opportunity to protect themselves from a medication error.	A 614	**3) The Resident Nurse and Administrator reviewed the medication administration practices to ensure all residents are offered the opportunity to utilize the unit-dose medication packaging system as an added safeguard against medication errors.** **4) To strengthen oversight of medication administration, the Resident Nurse has implemented a process of conducting random medication administration observations to evaluate caregiver compliance with medication administration policies and procedures.** **A standardized Medication Administration Observation Log 07-06-26 has been developed and implemented to document these observations, identify opportunities for improvement, provide immediate coaching when necessary, and verify continued compliance with facility policies and ADPH requirements.** **Any deficiencies identified during these observations will be addressed immediately through re-education, competency validation, and disciplinary actions up to and including termination if necessary.** **5) The Resident Nurse will perform ongoing random medication administration audits for a minimum of one (1) year and document findings using the Medication Administration Observation Log.** **The Administrator will review the completed observation logs monthly for a minimum of one (1) yearto ensure compliance with medication administration standards and verify that residents continue to be offered the opportunity to utilize the unit-dose medication packaging system during medication passes.** **All documentation will be maintained in the Administrator's office. The Regional Manager will review medication administration audits and observation logs during monthly compliance visits for a minimum of one (1) year to ensure sustained compliance. Any identified concerns will be corrected immediately through additional education, monitoring, and corrective action.**	
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer. A sanitizing			

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A 702	Continued From page 31 solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry. 4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight	A 702		

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A 702	Continued From page 32 container outside the ice bin. (c) Protection of Food from Contamination. 1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food. 3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor. 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded.	A 702		

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A 702	Continued From page 33 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times. 8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods). 10. Laundry shall not be brought through the food preparation or service area. (d) Storage and Service of Milk and Ice Cream. 1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.	A 702		

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A 702	Continued From page 34 2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is to be poured or drunk, will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident. 3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent	A 702		

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A 702	Continued From page 35 contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area. (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observation, record review and	A 702		

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A 702	Continued From page 36 interview, the facility failed to: 1) ensure food items were stored in a manner to protect them from potential contamination. 2) to ensure the only sink in the kitchen had soap and paper towels for hand hygiene 3) to have documentation logs demonstrating that the facility was monitoring for proper food storage temperatures and 4) the food temperature logs had not been completed since March 1, 2026. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On September 24, 2025, the ADPH received an anonymous complaint alleging no temperature monitoring for the refrigerator or freezer. On the afternoon of March 23, 2026, an observation was made of the kitchen. There were no paper towels to dry hands by the only handwashing sink in the kitchen. Also, there was no hands-free trash can so staff could dispose of paper towels without the potential for cross contamination. Record review revealed the temperature logs for the refrigerator and freezer had not been completed since March 18, 2026. Also, the food temperature logs had not been completed since March 1, 2026. In the dry storage area there was a case of food on the floor with another case of food on top of it. One of the shelves in dry storage had a tray on it with what appeared to be spilled food. On the afternoon of March 24, 2026, EI#10, the dietary manager, was asked why temperature logs were not up to date. EI#10 said she had worked sixteen days straight and had three more days to go. When asked why there was a food	A 702	**1) 420-5-4-.07 (2) Food Services (A 702)** The facility failed to comply with 420-5-4-.07(2) Food Service by failing to ensure food service operations were conducted in accordance with facility policy and Alabama Department of Public Health requirements. Specifically, the facility failed to ensure food items were stored in a manner that protected them from potential contamination, failed to maintain required hand hygiene supplies at the kitchen handwashing sink, failed to maintain required refrigerator, freezer, and food temperature monitoring logs, and failed to maintain clean and sanitary food storage areas. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility by increasing the risk of foodborne illness, cross-contamination, and unsafe food handling practices. Facility will perform adequate cleaning and maintenance of the kitchen and the kitchen equipment. 2) Comprehensive in-service education was provided to all applicable staff on March 31, 2026; April 22, 2026; May 27, 2026; and June 11, 2026. Training included: • Proper food handling and sanitation practices. • Infection prevention and hand hygiene requirements. • Proper food storage to prevent contamination. • Maintaining clean and organized food storage and preparation areas. • Proper waste disposal procedures. • Accurate completion and maintenance of all required dietary documentation and logs Attendance documentation has been maintained for each training session and are maintained in the Administrator's office. 3) **04-10-26** Administrator completed a thorough check of the kitchen to identify any other concerns not identified during the survey. No other deficiencies were found.	

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	D2705	A. BUILDING: _____ B. WING _____	C 03/25/2026

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A 702	Continued From page 37 spill on a tray in dry storage, EI#10 said it had spilled from a shelf above the tray. When asked why there were cases of food stacked on the floor, EI#10 said when the truck came, the cases were not put up as they should have been.	A 702	**4) The facility has taken immediate corrective action to address each cited deficiency and prevent recurrence.** **Immediate corrective actions included:** • **Paper towels were replaced in the kitchen hand washing area on March 24, 2026, to ensure proper hand hygiene.** • **A new covered trash receptacle was placed in the kitchen on March 26, 2026, to ensure waste is stored in suitable containers.** • **Dry food storage shelving and all food storage areas were thoroughly cleaned and sanitized on March 24, 2026, removing all food spillage and restoring sanitary storage conditions.** • **On March 24, 2026, Kitchen staff were instructed on maintaining clean cabinet shelving, proper food storage practices, sanitary food preparation and handling techniques, and the completion of all required food service documentation, including temperature and sanitation logs.** **5) The Dietary Manager or designated supervisor will complete routine kitchen sanitation inspections for a minimum of one (1) year to verify compliance with food handling practices, cleanliness of storage areas, proper waste disposal, availability of hand hygiene supplies, and completion of required food service documentation.** **All audit results and corrective actions will be maintained in the Administrator's office. The Regional Manager will review compliance documentation during monthly visits for a minimum of one (1) year to ensure sustained compliance. Any deficiencies identified during these reviews will be corrected immediately through re-education, additional monitoring, and corrective action as appropriate.**	
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available. (c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food	A 703		

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A 703	Continued From page 38 service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs. (d) Alternate food selections or substitutes shall be made available to all residents. (e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals. (f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post the current weekly menu in the food service area. Findings: On the morning of March 24, 2026, the surveyor observed the weekly menu was not posted. Later that morning EI#1 agreed the weekly menu should be posted.	A 703	**1) 420-5-4-.07 (3) Food Services (A 703)** **The facility failed to comply by failing to post the current weekly menu in the food service area as required. Based on observation and interview, the current weekly menu was not posted and was therefore unavailable for residents, staff, and visitors to review. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility by limiting residents' access to information regarding planned meals and their opportunity to make informed meal choices or communicate dietary concerns or preferences. Facility will ensure that the weekly menu is posted in food service area as required by with facility policy and Alabama Department of Public Health requirements.** **2) The deficiency was corrected immediately upon identification on 03-27-26. The current weekly menu was posted in the food service area in a location that is readily visible to residents, staff, and visitors. The facility has verified that the menu accurately reflects the meals being served.**	

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A1203	Continued From page 39	A1203		
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, Group, and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms. (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length insect screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, and stairwells in case of electrical power failure.	A1203	**3) Upon review by the Administrator of food service practices, no other deficiencies were found related to this citation.** **4) The Dietary Manager has implemented a process to ensure the weekly menu is updated, posted, and readily accessible in the food service area prior to the beginning of each menu week. A weekly dietary compliance checklist has been developed to verify that the current menu is posted and that any approved menu substitutions are documented for a minimum of one(1) year.** **The Administrator will verify the presence of the posted menu during routine environmental rounds.** **5) The Dietary Manager will verify weekly for a minimum of one (1) year that the current menu is posted and reflects the planned meals. Documentation of these checks will be maintained in the dietary department.** **The Administrator will review menu posting compliance during monthly environmental audits, for a minimum of one (1) year, with documentation maintained in the Administrator's office. The Regional Manager will review compliance during monthly visits for a minimum of one (1) year to ensure sustained adherence to ADPHrequirements. Any deficiencies identified will be corrected immediately through re-education and follow-up monitoring.**	

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A1203	Continued From page 40 As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30-36 inches above the floor and returned to	A1203		

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A1203	Continued From page 41 the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location. 3. Resident bedroom and other exit access doors in each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other special locking arrangements are permitted only in specialty care assisted living facilities. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. Exit doors of Family facilities may swing	A1203		

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A1203	Continued From page 42 inward. (m) Ventilation. The building shall be well-ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility. (n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance. 2. A visual inspection of each fire extinguisher shall be conducted monthly by designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (o) Call System. Except in Family facilities, a central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard. (p) Manufactured homes/mobile homes are not permitted.	A1203		

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A1203	Continued From page 43 (q) Fireplaces and inserts, shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens, or doors. (r) Exit marking. In Group and Congregate facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power. (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all assisted living facilities shall be in accordance with local electrical codes	A1203		

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A1203	Continued From page 44 and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide a functional call system for each resident. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: On March 16, 2026, the ADPH received an anonymous complaint alleging the call system was broken. On the evening of March 23, 2026, an observation was made of no call light present in a resident's room. This led to a house-wide search of each resident room. The following suites had no call light system. Suites two, three, four, five, six, eight, nine, ten, thirteen, fourteen, seventeen, eighteen, nineteen, twenty and twenty-three. Suites seven, sixteen and twenty-one had a call system device that did not work. The surveyor asked for an action plan to ensure all residents would be able to summon staff if they needed help. EI#1, EI#2 and the surveyor identified six residents who did not voice that they would use their cell phone to summon help/assistance or did not know what to do if they did need assistance. EI#1 and EI#2 educated these six residents on how to use "clappers" to summon for help or assistance. They return demonstration was observed by the surveyor.	A1203	1) 420-5-4-.12 (5) Physical Environment. The facility failed to comply with 420-5-4-.12(5) Physical Environment by failing to provide a functional call system for each resident as required. Based on observation, interview, and record review, multiple resident rooms either did not have a call system or had call system devices that were not functioning properly, preventing residents from reliably summoning staff for assistance. This deficient practice had the potential to affect all twenty-three (23) residents residing in the facility and presented an increased risk of delayed staff response during emergencies or when residents required assistance, potentially compromising resident health and safety. The facility will ensure that each resident has a functional call system available for use in summoning staff for assistance. 2) The Administrator and applicable staff received education regarding ADPH requirements for resident emergency communication systems and the facility's responsibility to ensure residents have an effective means of summoning assistance. 3) A review of residents affected by this citation was completed on 04-10-26. 4) The facility has assessed the resident's needs and a decision was made by July 15th to provide an alternate method for summoning staff assistance. This change is scheduled to be implemented by September 15th, 2026 and will promote resident safety and regulatory compliance.	

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A1203	Continued From page 45 On the afternoon of March 24, 2026, EI#11 was asked why residents were not provided a central electric or electronic call system. EI#11 said she felt like they did provide one. EI#11 said that the residents decided not to participate. She added it was a resident right not to participate. NOTE: Residents had to pay for a land line so that the system offered by the facility would work. Thus, residents were having to pay for the call system when the facility is required by regulation to conveniently provide a central electric or electronic call system. THERESA HARRISON, REGISTERED NURSE	A1203	5) The Administrator will conduct monthly environmental rounds to verify that each resident has access to a functional method of requesting assistance until an alternate permanent system is implemented. Documentation of these audits will be maintained in the Administrator's office. The Regional Manager will review compliance during monthly visits until a permanent alternative system is implemented. Any deficiencies identified will be addressed immediately through corrective action and additional monitoring.	

Teresa Sikes ALA 7/23/2026