STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 20, 2025, an unannounced licensure survey and complaint investigation was conducted for this 90 bed Specialty Care Assisted Living Facility (SCALF) with a census of 67. There were nine (9) complaints investigated during this survey. LC#20250303008, LC#20250113006, LC#20241217002, LC#20240918015, LC#20240801014 and LC#20240108010 were unsubstantiated. LC#20250219011, LC#20240606003 and LC#20240624014 were substantiated. There were deficiencies cited as a result of the complaint investigations. 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 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. The deficient practices resulted in the potential for harm to all 67 residents of the facility and require a plan of correction.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care 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:	A 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 301	Continued From page 1 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 ownership interest of 10 percent or more in the real property or building used by the specialty care 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.	A 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 301	Continued From page 2	A 301		

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 rules for SCALFs. The governing authority's lack of adequate oversight resulted in widespread deficient practices which placed all 67 residents of the facility at significant risk for harm due to this failure to apply the SBOH rules for the day-to-day operations of the facility.

Findings:

The Alabama Department of Public Health received nine complaints, three of which were substantiated during the onsite survey. The substantiated complaints included the following allegations: odors present, resident restraints used, fire drills not completed timely and an ineligible resident. Numerous additional deficient practices were identified during the onsite survey.

During the onsite survey the surveyors identified five (5) residents who did not meet the criteria for retention in the SCALF. These residents had numerous care concerns including requiring total assistance with care, unable to propel wheelchairs, unable to feed selves, requiring 2-4 person assistance for transfers, requiring partial or total assistance with turning, inability to make needs known and behaviors which affected the resident's wellbeing and infringed on the rights of other residents. Residents had not been properly assessed prior to admission and with significant changes to identify the need for additional care interventions or a higher level of care. The retention of these residents who did not qualify for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 301	Continued From page 3	A 301		

a SCALF resulted in additional deficient practices including the use of physical restraints to prevent them from getting up due to falls, inadequate care plans, urine odors throughout the facility, failure to provide a safe and decent environment and incidents not being reported to the ADPH as required.

In addition to resident care issues, the building and grounds were not maintained in a safe and sanitary manner. Trash and other items cluttered the outside area and odors were present. The building, including the gutters and vinyl siding, was in need of cleaning. Also, the kitchen was in need of repairs.

The surveyors spoke with Employee Identifier (EI)#20, Vice President of Clinical Operations/Sinceri Senior Living, by telephone during the onsite survey. EI#20 was also present by telephone for the exit conference as well as three additional members of the management team. EI#20 informed the surveyors that a member of the management team usually provided onsite management of the facility monthly and the team was available by telephone when needed. EI#1 informed the surveyors that the management team was supportive to her (EI#1).

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.

303 - Administrator duties were not fulfilled.
406 - Employees were not properly trained and training was not documented.
501 - The facility failed to make residents' medical records readily available for review and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 301	Continued From page 4	A 301		

copying.
504 - The facility failed to maintain confidentiality of residents' medical records and provide a safe and decent environment.
508 - Incidents were not reported to ADPH and investigated.
602 - Residents' medical examinations were incomplete or not completed timely.
604 - Residents were not properly assessed prior to admission, monthly and with significant changes in condition to evaluate the need for implementation of additional interventions for the care of the residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 10, 2022.
605 - Health supervision of residents was inadequate.
608 - Physical restraints were applied to residents of the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
611 - Facility care plans were not current and did not contain appropriate interventions to meet the care needs of the residents.
613 - The facility failed to obtain physician bedside medication orders for over-the-counter medication (OTC) plus physician orders for custody of prescription medications.
617 - Medication disposition was not performed upon discharge of residents or was incomplete.
621 - Residents were retained at the facility who did not meet the criteria for retention in a SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
702 - The facility failed to protect food from contamination and failed to ensure dishes were properly sanitized.
703 - The facility failed to provide less than 14 hours between the evening and breakfast meals.
804 - The food service area and kitchen were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 301	Continued From page 5 properly maintained and clean. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 901 - The facility's laundry room was not properly maintained. 1001 - The premises were not clean and properly maintained. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1002 - Cleaning supplies and flammable materials were not secured and a sanitary and comfortable environment was not provided. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1101 - The facility failed to conduct and document fire drills monthly and quarterly on each shift. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1206 - The facility failed to provide smoke detectors in residents' bedroom areas.	A 301		
A 303	420-5-20-.03 (2) (a) Administration. (2) The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the specialty care 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.	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 6	A 303		

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. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.

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 actually 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 7 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 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, interviews and record reviews, EI#1, Administrator, failed to adequately perform her (EI#1's) duties to ensure the proper and safe management of the day to day operations of the facility. In addition, EI#1 failed to ensure previously cited deficient practices were corrected and compliance with SBOH rules for SCALFs was maintained. These failures placed all 67 residents of the facility at significant risk of harm. Findings: On March 17-20, 2025, surveyors with the ADPH conducted an onsite survey and complaint investigation at the facility. Three of nine complaints investigated were substantiated during the onsite survey and numerous additional	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 8	A 303		

deficient practices were identified. The substantiated complaints included the following allegations: resident rooms had odors, use of physical resident restraints, fire drills not conducted timely, residents retained who did not meet the criteria for a SCALF and building not properly maintained.

EI#1 became administrator of the facility on November 2, 2021. The last state survey of the facility was performed on March 10, 2022 which was a follow up survey due to the facility's probational status. During that survey, a deficiency was cited for failure to perform resident assessments as required. The same deficiency was again cited during the current survey.

EI#1 failed to manage and direct staff activities in a manner that resulted in maintenance of a neat, clean and safe environment for residents, staff and visitors. Multiple complaints were received which alleged residents were not provided appropriate care including feeding, incontinent care, activities and responsiveness to concerns of family members. Although the number of staff on duty at the facility was adequate based on the number of residents, current residents of the facility had not been properly assessed and did not meet the criteria to be retained in a SCALF. These residents required total care including feeding, bathing, toileting, grooming, transferring and providing for safety. In an attempt to keep these residents safe from falls, the facility utilized restraints on the residents including the use of geriatric chairs, pushing beds against walls, siderails and lining the sides of beds with body pillows. Residents were placed in geriatric chairs and pushed to the common areas where they sat most of the day as staff were instructed to do so on the residents' care plans. Once the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 9	A 303		

were returned to their beds at night, some required turning and repositioning in the bed. Some residents were unable to make their needs known. At least one resident had a history of aggressive behaviors toward staff and other residents, requiring geriatric psychiatric admissions. This resident was currently refusing medications which could help to control these behaviors and had been refusing medications for at least two months. Odors were present inside the facility as well as on the premises. The facility was not clean. Smoke detectors had been removed from some residents' rooms. Residents were allowed to keep medications and chemicals in their rooms. The kitchen and laundry rooms were not properly maintained.

EI#1 failed to direct staff in providing requested information to the state surveyors. Information was requested repeatedly during the onsite survey and only portions of the requested information were eventually provided to the surveyors at the end of the survey. Residents' care could not be properly assessed by the surveyors due to this failure of the facility staff to comply with State rules for SCALFs.

EI#1 failed to ensure that staff completed required training and that the training was properly documented. Facility nurses were not trained in applying and managing the Libre continuous glucose monitoring system which was utilized by residents of the facility. Initial training of staff was not properly documented.

EI#1 failed to ensure that residents of the facility who had health and safety needs beyond the capability of the facility were promptly discharged or transferred to an appropriate setting. It was noted by the surveyors that residents were placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 10	A 303		

on hospice services within a few months of their admission to the facility. At least one of these residents remained at the facility on hospice services until the resident passed away. Residents were not properly assessed prior to admission and with significant changes to determine their appropriateness for admission to and/or retention in the facility. Residents' PSMS scores did not match observations of their current functional status. EI#1 failed to ensure that facility nurses provided observation and health supervision of residents and monitored for changes in their health and physical abilities then obtained placement for the residents in appropriate settings. The facility currently did not have a Care Coordinator to oversee the daily routine delivery of resident care. When interviewed on March 19, 2025, EI#2 informed the surveyors that the Care Coordinator had quit the previous week and there was currently no Care Coordinator. EI#2 was asked by the surveyors if she (EI#2) was the interim Care Coordinator and EI#2 answered "no".

EI#1 failed to ensure that care plans for all residents were current and appropriate. Facility care plans did not address all care needs of the residents or the current functional level of the residents. Restraints were documented as interventions on the care plans to prevent falls.

During an interview on March 18, 2025 at approximately 7:15 AM, EI#1 stated that it was hard to try to please families about concerns with residents. EI#1 stated that families did not have the financial means to place their loved ones in a facility of higher care or did not want them to leave this facility. EI#1 added that family members became frustrated when the cost of the facility increased but the increased rates were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 11	A 303		

necessary due to the increases in cost of living. EI#1 also stated it was a struggle to try to please everyone involved in a loved one's situation.

The following deficient practices were cited during the onsite survey due to a lack of management and oversight of the facility by the administrator. These deficient practices placed all 67 residents of the facility at significant risk of harm.

406 - EI#1 failed to ensure employees were properly trained and training was documented.
501 - EI#1 failed to make residents' medical records readily available for review and copying.
504 - EI#1 failed to maintain confidentiality of residents' medical records and provide a safe and decent environment.
508 - EI#1 failed to ensure incidents were reported and investigated.
602 - EI#1 failed to ensure residents' medical examinations were complete.
604 - EI#1 failed to ensure residents were properly assessed prior to admission, monthly and with significant changes in condition to evaluate the need for implementation of additional interventions for the care of the residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 10, 2022.
605 - EI#1 failed to ensure residents received adequate general observation and health supervision.
608 - EI#1 failed to ensure that physical restraints were not applied to residents of the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.
611 - EI#1 failed to ensure the facility care plans were current and contained appropriate interventions to meet the care needs of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 303	Continued From page 12 613 - EI#1 failed to ensure physician bedside medication orders for over-the-counter medication (OTC) and physician orders for custody of prescription medications were obtained. 617 - EI#1 failed to ensure medication dispositions were performed and properly documented upon discharge. 621 - EI#1 failed to ensure that residents were not retained at the facility who did not meet the criteria for retention in a SCALF. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 702 - EI#1 failed to ensure staff protected food from contamination and dishes were properly sanitized. 703 - EI#1 failed to ensure there was less than 14 hours between the evening and breakfast meals. 804 - EI#1 failed to ensure that the food service area and kitchen were properly maintained and clean. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 901 - EI#1 failed to ensure the facility's laundry room was properly maintained. 1001 - EI#1 failed to ensure the premises were properly maintained in a sanitary and decent manner. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1002 - EI#1 failed to ensure that cleaning supplies and flammable materials were secured and a sanitary, comfortable environment was maintained in the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1101 - EI#1 failed to ensure staff conducted and documented fire drills monthly and quarterly on each shift. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. 1206 - EI#1 failed to ensure smoke detectors were in residents' bedroom areas.	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 406	420-5-20-.04 (9) Personnel. (9) 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. An RN shall identify staff training needs and shall provide or arrange for needed training. 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 specialty care assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation. 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environmental safety.	A 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 406	Continued From page 14 (b) Prior to providing any resident care, all staff shall complete The Dementia Education and Training Act (DETA) Care Series Training developed by the Alabama Department of Mental Health or equivalent training approved by the State Health Officer. All licensed staff shall complete DETA Brain Series Training, The Pharmacological Management of Dementia, and the Dementia Assessment Series provided by the DETA Program or equivalent training approved by the State Health Officer prior to resident contact. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained. (c) All staff who have resident contact shall be able to demonstrate diversional methods and redirection. All staff shall be able to demonstrate an understanding of the implications of caring for residents with agnosia, amnesia, aphasia, and apraxia. All staff shall be able to demonstrate an understanding of the facility's fire and evacuation plan and all other policies regarding safety, including policies for preventing elopements, responding to elopements, and fall prevention. (d) Cardiopulmonary Resuscitation. A specialty care 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 a specialty care assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. A specialty care assisted living	A 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 406	Continued From page 15 facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or the American Red Cross in CPR or AED utilization. (e) 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. (f) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interviews, employees were not properly trained and training was not documented. Finding: Review of employee files on March 19, 2025 revealed the following information. Documentation of Employee Training The employee file for EI#11 did not contain documentation of training in State law and rules on SCALFs, advance directives, oxygen safety,	A 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 406	Continued From page 16 diabetes training, hospice training and DETA Care Series. Employee files for EI#8 and EI#9 did not contain documentation of training in State law and rules on SCALFs, advance directives, oxygen safety, hospice training, diabetes training, DETA Brain Series, DETA Assessment Series and pharmacological management of psychotropic drugs. EI#3 stated that she (EI#3) was responsible for initial employee training. EI#3 also stated the checklist for documentation of initial employee training had changed but that the training was being completed, just not documented on the current checklist. Special Needs Training Not Completed There was no documentation of training in use of the Libre continuous blood glucose monitoring system for EI#8, Licensed Practical Nurse (LPN) and EI#9, LPN. Both EI#8 and EI#9 stated they (EI#8 and EI#9) had not been trained by the facility in the use of the Libre system.	A 406		
A 501	420-5-20-.05 (1) Records and Reports. (1) General. (a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence. (b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the specialty care assisted living facility premises.	A 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 501	Continued From page 17 (c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access. (d) All facility records, including resident medical records, shall be made readily available for review and copying by representatives of the Alabama Department of Public Health upon request. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to make residents' medical records readily available for review and copying by the Alabama Department of Public Health surveyors upon request. Findings: On March 19, 2025 and again on March 20, 2025, the surveyors attempted to review facility records for residents. On March 19, 2025, the surveyors were informed by EI#2 that information on the residents was documented in a computer system. The surveyors requested access to the residents' records on the computer system but it was not provided. Instead, EI#2 stated she (EI#2) would print the information requested by the surveyors. The surveyors were able to locate paper charts which contained some information on the resident sample in a supervisor's office. These charts had not been offered to the surveyors but surveyors were allowed to review the charts when requested.	A 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 501	Continued From page 18 At approximately 3:10 PM on March 19, 2025, the surveyors requested verbally and in writing, from EI#2, the following information on an identified sample of resident files: all resident assessments, medical examinations, monthly assessments with weights, incident reports with investigations, care plans, medication administration records. This information was not provided on March 19, 2025 but was promised by EI#2 to be available when the surveyors returned on March 20, 2025. When the surveyors entered the facility on March 20, 2025, EI#2 informed the surveyors that the requested information had not been printed due to a computer/printer issue. At that time, the requested information was promised to the surveyors by 9:00 AM on March 20, 2025. The requested information had not been provided to the surveyors by 9:00 AM on March 20, 2025 and was requested from EI#1 by the surveyors at that time. EI#1 was provided with a list of requested information. EI#2 began gradually providing portions of the requested information over the next few hours but surveyors were never provided with all requested information during the survey. This failure to provide requested information to the surveyors limited the surveyors' ability to properly assess the residents' history at the facility. Surveyors were not offered access to a computer at the facility until they requested to meet with EI#1 on the afternoon of March 20, 2025 to conduct an exit conference. EI#1 then informed the surveyors they could use her (EI#1's) laptop to access requested information. EI#1 was informed by the surveyors that the survey had been completed at that time and only information provided prior to exit from the facility would be used for the survey.	A 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 19	A 504		
A 504	420-5-20-.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 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	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 20	A 504		

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 21 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 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:	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 22 (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. (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. (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.	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 23 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 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, and 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. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 24 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. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain resident confidentiality of medical records. The facility also failed to provide a safe and decent environment for the residents, staff and the public. Findings: Resident Confidentiality On March 18, 2025 at approximately 4:50 PM, the surveyor observed a medication cart located near the activity/television room with numerous residents present. The medication cart contained the nurse's laptop computer which was opened to a resident's profile. The resident profile contained medication and medical history information and was visible to anyone in the area. Safe and Decent Environment The following deficient practices were observed during the onsite survey and contributed to the facility's failure to provide a safe and decent environment. *During a facility tour on March 19, 2025, the following observation was made. The facility's training room door was not locked and the surveyor entered freely. The training room contained blood tubes, needles for blood draws and disinfectant wipes.	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 504	Continued From page 25 *Residents were allowed to keep medications in their rooms. *Smoke detectors were not present in all residents' rooms. *Residents were physically restrained. *Staff were not properly trained. *Residents were retained at the facility who did not meet the criteria for a SCALF. *Chemicals and flammable materials were unsecured. *Odors were present inside and outside the facility. *Residents were not properly screened for admission and retention in the SCALF. During an interview on March 20, 2025, EI#1 agreed with the surveyors' findings from the onsite survey.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 26	A 508		

that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought.

(ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact.

(iv) Elopement by a resident.

(v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules.

(vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules.

(vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules.

(viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 27 Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 28 (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 29 (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 30	A 508		

God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility.

(v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.

(vi) An unplanned occurrence that results in media attention.

(vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician.

(viii) Ingestion by a resident of a toxic substance that requires medical attention.

(ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

(x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device.

4. The report to the Department's Online Incident Reporting System shall include the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 31 (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 32	A 508		

This Rule is not met as evidenced by:
Based on record reviews, the facility failed to report incidents to the ADPH Online Incident Reporting System (OIRS) and failed to investigate the incidents.

Findings:

Residents' facility incident reports and investigations were requested on March 19, 2025 but were not received until March 20, 2025 as the survey was ending. The incident reports and investigations that were received were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on reviews of records that were provided.

Resident Identifier (RI)#1

RI#1 was admitted to the facility on July 31, 2019 with diagnoses that included dementia, chronic renal insufficiency, gastroesophageal reflux disease, hypertension, hyperlipidemia, insomnia, and neuropathy. RI#1 sustained a fall and went to the emergency room (ER) on April 10, 2023, with a diagnosis of an abrasion to right knee, contusion to right knee, fall and head injury. After review of the OIRS this incident was not reported. No incident investigation was provided to the surveyors during the onsite survey when requested from EI#2.

RI#4

RI#4 was admitted to the facility on January 22, 2024 and had diagnoses which included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 508	Continued From page 33 dementia with behavioral disturbance, hypothyroidism, diabetes mellitus type 2, hypertension and cognitive communication deficit. RI#4 sustained a fall at the facility on August 10, 2024 which resulted in pain to the left side with an x-ray being ordered. The incident was not reported to the OIRS. No incident investigation was provided to the surveyors during the onsite survey when requested from EI#2. RI#10 RI#10 was admitted to the facility on October 30, 2023 with diagnoses that included dementia, obsessive compulsive disorder, mixed anxiety, hypertension, hypothyroidism and osteoporosis. RI#10 sustained falls at the facility on January 24, 2025 and on March 3, 2025 requiring ER visits. Discharge paperwork from the ER on January 24, 2025 stated closed head injury and fall. Discharge paperwork from the ER on March 3, 2025 stated head contusion. After review of the OIRS these incidents were not reported. No incident investigation was provided to the surveyors during the onsite survey when requested from EI#2.	A 508		
A 602	420-5-20-.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 a specialty care assisted living facility, the resident or prospective resident shall be examined by a physician. For purposes of the initial physical examination, a physician currently licensed and in good standing with the Medical Licensure Commission of any state may	A 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 602	Continued From page 34	A 602		

complete this physical assessment. The physician shall report his or her findings in writing to the facility. This examination is not required for a resident of a facility dually licensed as an assisted living facility and as a specialty care assisted living facility in those cases when the resident is transferred from the assisted living unit to the specialty care assisted living unit in the same 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 602	Continued From page 35	A 602		

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 condition.

4. Changes in medications prescribed (name, dosage, and strength of drug, frequency, and route of administration).

5. Changes in treatment.

(c) Change of Condition Physical Examinations. Changes in the resident's condition that require a physician examination and result in a change in diagnoses, condition, 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. Changes in diagnoses.

2. Changes in condition.

3. Changes in medications prescribed (name, dosage and strength of drug, frequency, and route of administration).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 602	Continued From page 36 4. Changes in treatment. This Rule is not met as evidenced by: Based on record reviews, residents' medical examinations were incomplete. Findings: Residents' medical examinations were requested on March 19, 2025 but were not received until March 20, 2025 as the survey was ending. Medical examinations were not provided for all seventeen residents as requested. The medical examinations that were received were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on reviews of records that were provided. RI#5 RI#5 was admitted to the facility on October 22, 2024, with diagnoses that included urinary tract infection, anxiety, dementia, asthma, hypothyroidism, hypertension, chronic obstructive pulmonary disease, candidiasis, falls and thrombocytosis. RI#5 had a medical examination from March 11, 2025, but not an initial medical examination. No Initial Medical Examination was provided to the surveyors when requested from EI#2. RI#6 RI#6 was admitted to the facility on June 7, 2024 and had diagnoses which included diabetes mellitus type 2, chronic kidney disease stage 3,	A 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 602	Continued From page 37 dementia, recurrent falls and depression. RI#6's Initial Medical Examination was dated May 6, 2024 (greater than 30 days prior to admission) and did not contain RI#6's weight. RI#13 RI#13 was admitted to the facility on July 3, 2024 and had diagnoses which included dementia, depression, insomnia, hypertension and mutism. No Initial Medical Examination was provided to the surveyors when requested from EI#2. The first medical examination provided to the surveyors was signed August 1, 2024, one month after RI#13's admission to the facility.	A 602		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 38 The facility RN shall perform a comprehensive assessment of each prospective resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments. (b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care. (c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems: 1. Weight loss: (i) Each month, the facility shall accurately weigh and record the weight of each resident. (ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 39 unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on observations, record review and interview, residents were not properly assessed prior to admission, monthly and with significant changes in condition to evaluate the need for implementation of additional interventions for the care of the residents.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 40 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON MARCH 10, 2022. Findings: Residents' facility records were requested on March 19, 2025 but were not received until March 20, 2025 as the survey was ending. The facility failed to provide to the surveyors all requested records in their entirety, making it difficult for the surveyors to determine if resident assessments had not been completed or were not provided to the surveyors during the onsite survey. The resident records that were provided were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on review of the records that were provided, observations of residents and interviews with facility staff during the onsite survey. Limited information provided from seventeen resident records, current and discharged, was reviewed. Numerous resident assessments were either not provided to surveyors or not completed. These assessments included monthly assessments and weights (primarily prior to 2025), pre-admission screenings (clinical history, mental status examination, aphasia screening, geriatric depression screen, PSMS, behavior screening and comprehensive assessment), upon admission assessments (PSMS and behavior screening) and change of condition assessments to include comprehensive assessments, PSMS and behavior screenings. The omitted assessments were widespread throughout the charts reviewed making it difficult or impossible for surveyors to adequately survey the residents' status upon admission and	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 41 throughout their stay at the facility. Entries documented in residents' hospice records did not match the information provided to surveyors which had been documented by the facility staff regarding residents' functional status. PSMS scores did not match the current functional status of residents as observed during the onsite survey. Residents had not been properly assessed to determine their needs and to develop appropriate interventions to meet those care needs upon admission and throughout each resident's stay at the facility, placing each resident at significant risk of harm and decline in condition.	A 604		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on observations, interviews and record	A 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 605	Continued From page 42	A 605		

reviews, the facility failed to provide general observation and health supervision of the residents to ensure arrangements were made for the residents to obtain necessary services.

Findings:

Residents' facility records were requested on March 19, 2025 but most were not received until March 20, 2025 as the survey was ending. Only a portion of the information requested by surveyors was provided to the surveyors. The resident records that were received were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on review of records that were provided, observations of residents and interviews with facility staff during the onsite survey.

As noted in deficiencies 501 and 604, residents of the facility were not properly assessed or the assessments of the residents were not provided to the surveyors during the onsite survey. Due to this lack of observation and health supervision, residents were retained at the facility who required a higher level of care than the facility was licensed to provide. At least four current residents of the facility did not meet the requirements for a SCALF. These residents required feeding, total care, physical restraints and repositioning. Some had difficulty swallowing placing them at high risk for aspiration. One was uncooperative and noncompliant with care. One resident had passed away recently at the facility, only three months after admission. Some residents were placed in geriatric chairs to provide support to sit which was not provided in standard wheelchairs and enabled them to sit upright. Some residents were unable to make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 605	Continued From page 43 their needs known. These residents were not properly supervised and arrangements made for placement in a facility that was licensed and able to meet their care needs.	A 605		
A 608	420-5-20-.06 (3) (j) Care of Residents (j) Mechanical Restraint and Seclusion. No form of physical restraint or seclusion shall be applied to residents of a specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall use the least restrictive intervention that will be effective to protect residents, immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in a specialty care assisted living facility. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, physical restraints were applied to residents of the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health	A 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 608	Continued From page 44	A 608		

received a complaint which alleged residents were restrained. The surveyors were able to substantiate this complaint during the onsite survey as residents were physically restrained by multiple methods.

As noted previously, residents' facility care plans and records were not received until the end of the onsite survey and were reviewed by surveyors after the onsite survey ended. Observations of residents were made during the onsite survey.

At multiple meals during the onsite survey, RI#1 and RI#2 were observed in geriatric chairs being pushed to the dining room. RI#1 and RI#2 did not assist with propelling the chairs. Also, RI#14 (who passed away at the facility recently) had an order for a geriatric chair "as the patient repeatedly tries to stand in wheelchair and has frequent falls". A hospice note for RI#14, dated February 11, 2025, read "will order Dynergo (geriatric) chair to help prevent patient standing and falling". This indicates that the geriatric chairs were in use to help prevent these residents from attempting to get up which is a form of restraint.

RI#14's facility care plan read "bed to wall...use body pillow to define edges of bed". Fall Interventions on RI#2's facility care plan read "place body pillow on right side of (him/her) when in bed...one side of bed placed against the wall...mobility chair". Fall Interventions on RI#4's facility care plan read "one side of bed placed against the wall...place body pillow on right side of (him/her) when (he/she) is in bed". These measures were in use to prevent the residents from getting out of bed independently and were a form of restraint.

The use of physical restraints at the facility was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 608	Continued From page 45 discussed with EI#1 on March 20, 2025 who agreed with the surveyors' findings.	A 608		
A 611	420-5-20-.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. The RN shall develop written plans of care for each resident prior to or at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. 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.	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 46 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 a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' 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	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 47 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 observations, interviews and record reviews, residents' facility care plans were not current and did not contain appropriate interventions to meet the care needs of the residents. Findings: Residents' facility care plans were requested on March 19, 2025 but were not received until March 20, 2025 as the survey was ending. Care plans were not provided for all seventeen residents as requested. The care plans that were received were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on review of records that were provided, observations of residents and interviews with facility staff during the onsite survey. *Fall Interventions included physical restraints such as placing beds against the wall, placing body pillows on one side of the bed and use of geriatric chairs which were not appropriate interventions for a SCALF. *Eating interventions did not match what was being done such as intervention was "supervise and cue" and the resident was observed being fed by staff.	A 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 48 *Transfer interventions did not match what was being done. The care plan stated "total assist x 1" and the resident required 2 people to transfer or more than 2 people. *Residents who required incontinent care did not have interventions to provide care at least every 2 hours to prevent skin breakdown. *Residents who required repositioning did not have interventions to reposition every 2 hours. *Specific major disease processes (such as diabetes, hypertension, congestive heart failure) were not addressed with signs and symptoms of the disease processes that staff should monitor for and report. *Visual deficits were not documented. *The number of staff required to complete an intervention was unclear. Some care plans listed interventions twice with one entry stating 1 person assistance and the second entry stating 2 person assistance. *The care plans did not address the residents' current functional status. Some care plans described a functional status above the current functional level of the resident.	A 611		
A 613	420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications, as defined in these rules, shall be prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination.	A 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 613	Continued From page 49 (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Medication administration, as defined in these rules, shall be conducted only by a physician or an RN or LPN. An RN or LPN shall administer medications to residents in the specialty care assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A current copy of A Short Practical Guide for Psychotropic Medications in Dementia Patients or the equivalent shall be in each specialty care assisted living facility as a reference guide. This Rule is not met as evidenced by: Based on observations and record reviews, the facility failed to obtain physician's bedside medication orders for over the counter medication (OTC) and physician's orders for custody of prescription medications. Findings:	A 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 613	Continued From page 50 RI#1 OTC Medication RI#1 was admitted to the facility on July 31, 2019, with diagnoses that included dementia, gastroesophageal reflux disease, hypertension, hyperlipidemia, insomnia, neuropathy and chronic renal insufficency. During a surveyor observation of caregivers assisting RI#1, Chamosyn with honey ointment was noted in RI#1's room. During records review on March 19, 2025, at approximately 7:45 AM, RI#1's medical examination dated for August 11, 2023, did not have any physician's bedside orders for RI#1's medications. The surveyors requested a current medical examination but the facility did not provide any additional information. RI#5 Prescription Medication RI#5 was admitted to the facility on October 22, 2024, with diagnoses that included urinary tract infection, anxiety, dementia, hypothyroidism, hypertension, chronic obstructive pulmonary disease, candidiasis, thrombocytosis and falling. During a facility tour on March 17, 2025, at approximately 1:10 PM, the following was observed. The surveyor observed Mupirocin ointment on dresser in RI#5's room. Upon records review on March 19, 2025, at approximately 7:45 AM, RI#5's medical examination dated March 11, 2025, did not have any physician orders for RI#5 to maintain custody of prescription medication. EI#1 agreed with the surveyors' findings.	A 613		
A 617	420-5-20-.06 (6) Care of Residents. (6) Disposal of Medications.	A 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 617	Continued From page 51 (a) Controlled substances and legend drugs dispensed to residents, that are expired or unused because the medication is discontinued or because the resident dies, shall be destroyed within 30 days. Unused legend drugs that are not expired may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et. seq. Under no circumstances shall expired, discontinued, or unused medications be stored or housed in the facility beyond 30 days. (b) Medications of residents who are discharged or transferred to another facility shall be returned to the residents. The responsible party will sign a statement that these medications have been received. The statement shall list the pharmacy, prescription number, date, resident's name, and strength of the medication and the amount. This statement shall be maintained in a file for at least three years. (c) When medications are destroyed on the premises of the specialty care assisted living facility, a record shall be made and retained for at least three years. This record shall include: the name of the specialty care assisted living facility, the method of disposal, the pharmacy, the prescription number, the name of the resident, the name, strength, and dosage of the medication, and the amount and the reason for the disposal. This record shall be signed and dated by the individual performing the destruction and by at least one witness. This Rule is not met as evidenced by: Based on record reviews and interviews,	A 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 617	Continued From page 52	A 617		

disposition of residents' medication upon discharge of the residents from the facility was not properly documented or not documented at all.

Findings:

Upon record review, on March 19, 2025 at approximately 7:45 AM, the following information was obtained.

RI#15 was admitted to the facility on November 13, 2024, with diagnoses that included coronary artery disease, dysphonia and vocal fold atrophy. RI#15 had been discharged from the facility. RI#15's chart did not contain a medication disposition upon discharge.

RI#16 was admitted to the facility around September 5, 2024 (a definite date was not provided) and had diagnoses which included high blood pressure, Alzheimer's disease and diabetes mellitus type 2. RI#16 was discharged from the facility on November 3, 2024 to the care of family. RI#16's medications were released to RI#16's family who signed a Medication Release Form which listed RI#16's medications. The form did not contain the prescription numbers for each medication.

RI#17 was admitted to the facility on November 7, 2023 with diagnoses that included atrial fibrillation, congestive heart failure, chronic kidney disease stage 3, diabetes mellitus type 2, hypertension, hyperlipidemia, prostate cancer, neuropathy, osteoarthritis, depression, chronic obstructive pulmonary disease, and anemia. RI#17 had been discharged from the facility. RI#17's chart did not contain a medication disposition upon discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 617	Continued From page 53 EI#1 agreed the forms were incomplete.	A 617		
A 621	420-5-20-.06 (9) (b) Care of Residents. (b) Retention. 1. A specialty care assisted living facility shall not allow any resident to return to the specialty care assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the specialty care assisted living facility is licensed to provide or the facility is capable of providing. 2. A specialty care assisted living facility shall not retain a resident that has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming, bathing or a score of four or five in physical ambulation. 3. A specialty care assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 4. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in a specialty care assisted living facility. 5. A specialty care assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 54 (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive ability to direct his or her own care and the individual is able to direct facility staff and does direct facility staff to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance. 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. 6. If a resident of a specialty care assisted living facility is diagnosed with a terminal illness and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for specialty care assisted living facilities. The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 55	A 621		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, residents were retained at the facility who did not meet the criteria for retention in a SCALF.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

The Alabama Department of Public Health received a complaint which alleged a resident did not meet the criteria for retention in a SCALF. The surveyors were able to substantiate this complaint and identified multiple residents of the facility who did not meet the criteria to remain in the SCALF.

Residents' facility records were requested on March 19, 2025 but were not received until March 20, 2025 as the survey was ending. The records provided to the surveyors did not include all records requested. The resident records that were received were reviewed after exit from the facility and, therefore, were not discussed with staff. The following deficient practices were identified based on review of records that were provided, observations of residents and interviews with facility staff during the onsite survey.

RI#1

RI#1 was admitted to the facility on July 31, 2019, with diagnoses that included dementia, chronic renal insufficiency, gastroesophageal reflux

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 56	A 621		

disease, hypertension, hyperlipidemia, insomnia, and neuropathy. Upon entering the facility on March 17, 2025, the surveyors observed lunch and RI#1 was sitting at a dining table in a geriatric chair (a chair which provides extra support to individuals who have difficulty sitting in conventional wheelchairs). RI#1 had a caregiver present at the lunch table for assistance with feeding.

On the morning of March 19, 2025, the surveyors observed two staff members (EI#15 and EI#19) transfer RI#1 to the bed with one staff member holding under RI#1's arms and one staff member holding under RI#1's knees using a total lift. RI#1 was transferred to the hospital bed and his/her diaper was changed by staff members due to RI#1 being incontinent of bladder and bowel. RI#1 did not speak and did not provide any assistance. The surveyor asked if RI#1 could ambulate and they (EI#15 and EI#19) answered "no". EI#15 and EI#19 also stated that staff must place RI#1 in bed and place a mat on the floor in case RI#1 falls out of the bed. EI#15 and EI#19 also stated RI#1's bed was pushed up against the wall and the siderails were raised at night. RI#1's bed was currently pushed up against the wall.

Review of RI#1's records, on March 19. 2025 at approximately 7:45 AM, revealed the following. Per a hospice document dated January 25, 2025, "(RI#1) appears to be oriented x 1 and responds to (RI#1's) name but is unable to say it". "(RI#1) is not able to make any need known or communicate his/her thoughts". "Does not follow commands". "(RI#1) is able to take a few steps with max assist from two (2) staff members, otherwise chair/bed bound". "(RI#1's) appetite varies, and often declines a meal". "(RI#1) began pocketing food and (RI#1's) diet was changed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 57	A 621		

mechanical soft foods only"."(He/She) requires being fed most times". "(RI#1) remains a high aspiration risk". Hospice SOAP note, dated for February 1, 2024, read "(RI#1) has had an overall decline cognitively over the past several months". "(RI#1) has had an overall decrease in appetite. (He/She) is currently a feeder and unable to feed (himself/herself) unless it is small finger foods". "(RI#1) is nonverbal at this time". Per RI#1's care plan dated March 19, 2025, under assistive devices, "(RI#1) is not mobile requires assistance for mobility". RI#1 had a Physical Self-Maintenance Scale (PSMS) done by the facility on March 13, 2025, with an overall score of 24 with a score of 4 in ambulation which was above the level allowed in a SCALF. The facility did present a 30-day discharge notice to the surveyors that was dated for March 14, 2025. Review of the above documentation and interviews with facility staff indicated RI#1's functional status was below the level allowed in a SCALF prior to March 14, 2025 but RI#1 had not been assessed to determine the need for a higher level of care until March 13, 2025.

RI#2

RI#2 was admitted to the facility on February 28, 2024 and had diagnoses which included advanced dementia, congestive heart failure, atrial fibrillation, hypertension, depression and anxiety. During the onsite survey, RI#2 was observed mainly in a geriatric chair (a chair which provides extra support to individuals who have difficulty sitting in conventional wheelchairs) being pushed from place to place by staff. RI#2 was thin and required feeding assistance by a staff member at meals. At mealtimes during the survey, RI#2 was observed seated in the geriatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 58	A 621		

chair in the dining room, pushed up to the table and being fed by a staff member. RI#2 did not respond verbally when spoken to by surveyors. Staff informed the surveyors that they were instructed by the nurses not to put RI#2 in the bed during the day due to high risk of RI#2 falling from the bed. RI#2 was incontinent of bowel and bladder and required the use of diapers which were changed by facility staff to mange the incontinence.

On the morning of March 19, 2025, the surveyors observed two staff members (EI#13 and EI#16) transfer RI#2 from the geriatric chair to the toilet then back to the geriatric chair. RI#2 was transferred with one staff member holding under each arm and pulling RI#2 to a standing position. RI#2 did attempt to hold to the hand rail on the wall after standing when RI#2's hands were placed on the rail by staff. RI#2 did not assist with pivoting toward the toilet and toward the chair. RI#2 did not ambulate during the transfer process. Multiple staff members informed the surveyors that RI#2 was unable to ambulate. RI#2 was unable to make his/her needs known. Once seated in the geriatric chair, RI#2 was asked by staff to independently move the geriatric chair and RI#2 did not do so. EI#13 and EI#16 informed the surveyors that RI#2 would sometimes randomly move the chair with his/her feet but did not purposefully move the chair to command. EI#13 and EI#16 also informed the surveyors that RI#2 required total care from staff and would sometimes try to get up once put in the bed; therefore, pillows were used in RI#2's bed to prevent RI#2 from getting up.

Review of RI#2's facility record, on March 20, 2025, revealed the following. A hospice note, dated January 21, 2025, read "...weak and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 59 frail...high fall risk...slow to chew and swallow and is an aspiration risk...". An Annual Medical Examination, dated February 12, 2025, read "functional decline, frequent falls, decreased appetite and weight loss, less mobile, mostly chairbound, requiring maximum assistance for 5/6 ADLs (activities of daily living)...aspiration risk due to dysphagia...". A PSMS for RI#2, completed by EI#2 on March 4, 2025, documented a score of "3f" in Physical Ambulation (ambulates with assistance of wheelchair-needs help getting in/out). No documentation of a more recent PSMS was provided to the surveyors even though all assessments were requested multiple times during the survey. The current score (observed by surveyors) would have been a 4 in Physical Ambulation (sits unsupported in chair or wheelchair, but cannot propel self without help) which was above the level allowed in a SCALF. As noted above, a geriatric wheelchair was provided to ensure RI#2 was able to sit unsupported in a chair. Under Fall Interventions on RI#2's facility Care Plan were the following entries: "place body pillow on right side of (him/her) when in bed as (he/she) will allow...keep in high traffic area until (he/she) becomes sleepy before putting to bed as (he/she) will allow...one side of bed placed against the wall". These interventions were in place to assist in preventing falls from the bed due to RI#2's documented history of multiple falls. On March 19, 2025, RI#2's bed was observed with one side pushed against the wall and pillows lining the opposite side of the bed. RI#2's current functional status did not meet the requirements to remain in a SCALF, placing RI#2 at extreme risk of harm due to skin breakdown, falls or aspiration.	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 60 RI#8 RI#8 was admitted to the facility on January 13, 2025, with diagnoses that included benign prostatic hyperplasia, chronic pain, constipation, dementia, depression, hypertension, hyperlipidemia, insomnia, neuropathy, and chronic obstructive pulmonary disease. The surveyors observed the following during breakfast on March 18, 2025, at approximately 8:00 AM. RI#8 was observed in a wheelchair sitting at the table and did not speak when spoken to by the surveyor. A caregiver sat with RI#8 to assist with feeding RI#8. The surveyor asked EI#10 if RI#8 always needs assistance with feeding and EI#10 answered "yes". The surveyor observed that RI#10 did not eat much for breakfast. On the morning of March 19, 2025, the surveyors observed four staff members (EI#13, EI#14, EI#15, and EI#16) assisted RI#8 to the toilet and back to the wheelchair. RI#8 was incontinent of bladder and bowel and required total assistance to change diaper. RI#8's weight was 230 pounds according to the monthly assessment for March 2025. RI#8 did not provide any assistance with toileting and the transfer was difficult requiring 4 staff members for safety purposes. RI#8 did not speak and did not demonstrate any purposeful movement of the wheelchair once seated back in the wheelchair. Review of RI#8's records, on March 19, 2025 at approximately 7:45 AM, revealed the following information. According to a change in condition report, dated for March 13, 2025, RI#8 had severe cognitive impairment, occasionally resisted care, moderate fall risk, and required physical assistance with transfers. Per RI#8's monthly assessment for the month of March	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 61	A 621		

2025, "resident had noted decline in cognition, weight, and physical maintenance, received order to have resident evaluated and admitted to hospice if appropriate". This decline was documented only two months after RI#8 was admitted to the facility. RI#8 was currently receiving hospice services at the facility.

RI#13

RI#13 was admitted to the facility on July 3, 2024 and had diagnoses which included dementia with behavioral disturbance, depression, insomnia, hypertension, mood disorder and mutism. RI#13 was ambulatory with a walker. Review of RI#13's facility record, on March 20, 2025, revealed the following information. RI#13 had a history of geriatric psychiatric admissions due to aggressive behaviors. On August 12, 2024, RI#13 was aggressive, combative and refused care assistance. On September 4, 2024, RI#13 was combative with staff and other residents. On October 16, 2024, RI#13 was sent to a geriatric psychiatric facility due to aggressive behaviors. On November 4, 2024, RI#13 was involved in an altercation with another resident and was sent to a geriatric psychiatric facility. While at the psychiatric facility, on November 27, 2024, RI#13, reportedly unprovoked, attacked a staff member and began punching the staff member in the head. On January 29, 2025, RI#13 exhibited aggressive behaviors at the SCALF and was started on Invega (antipsychotic medication).

Facility nurses reported to the surveyors that RI#13 was currently refusing medications and had done so for 1-2 months. Review of RI#13's Medication Administration Records (MARs) for the months of February and March 2025 revealed the following information. In February 2025, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 62 following medications were ordered by RI#13's physician and refused by RI#13: Amlodipine 25 milligrams one tablet twice daily (blood pressure) was not given/refused 14 doses; Atorvastatin 20 milligrams one tablet daily (high cholesterol) was not given/refused 4 doses; Buspirone 30 milligrams one tablet twice daily (anxiety) was not given/refused 13 doses; Clonidine 0.1 milligrams one tablet twice daily (blood pressure) was not given/refused 13 doses; Diclofenac gel 1 percent topically to the affected area four times a day (pain/arthritis) was not given/refused 30 doses; Ferrous Sulfate 325 milligrams one tablet every day (iron supplement) was not given/refused 4 doses; Hydrochlorothiazide 12.5 milligrams one capsule every day (blood pressure) was not given/refused 8 doses; Imipram 25 milligrams one tablet every night at bedtime (depression) was not given/refused 7 doses; Memantine 5 milligrams twice daily (dementia) was not given/refused 12 doses; Mirtazapine 30 milligrams once daily at bedtime (anxiety) was refused 8 doses; Oxycarbazepin 300 milligrams twice daily (mood) was not given/refused 13 doses; Pantoprazole 40 milligrams daily before breakfast (gastrointestinal disorders) was refused 14 doses; Quetiapine 100 milligrams three times daily (depression/mood disorders) was not given/refused 19 doses; Risperidone 1 milligram three times daily (mood disorders/dementia) was refused 8 doses. In March 2025, the following medications were ordered by RI#13's physician and refused by RI#13: Amlodipine 5 milligrams twice daily was refused 11 doses; Buspirone 30 milligrams twice daily was refused 11 doses; Clonidine 0.1 milligrams twice daily was refused 11 doses; Diclofenac gel 1 percent four times daily was refused 19 doses; Hydrochlorothiazide 12.5 milligrams once daily was refused 5 doses; Imipram 25 milligrams every night at bedtime was	A 621		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 63	A 621		

refused 6 doses; Memantine 5 milligrams twice daily was refused 11 doses; Mirtazapine 30 milligrams every night at bedtime was refused 6 doses; Oxycarbazepin 300 milligrams twice daily was refused 9 doses; Pantoprazole 40 milligrams every day was refused 13 doses; Quetiapine 100 milligrams three times daily was refused 8 doses; Risperidone 1 milligram every day was refused 3 doses.

RI#13 had exhibited aggressive behaviors with both staff and other residents for several months. RI#13 was currently refusing to take medications which could help to control these behaviors and had refused these medications for at least two months. On the morning of March 19, 2025, the surveyors observed EI#10 attempt to administer morning medications to RI#13 in the television room. RI#13 put the pills in his/her mouth and took water then held the water and pills in his/her mouth. EI#10 attempted repeatedly to get RI#13 to swallow the medications but he/she refused and eventually spit the water and the medications on the floor and attempted to hit EI#10. RI#13's behaviors, noncompliance with plan of care and refusal of medications posed a threat to RI#13's wellbeing as well as to other residents. No 30-day discharge notice had been issued to RI#13 at the time of the onsite survey.

RI#14

RI#14 was admitted to the facility on December 12, 2024 and had diagnoses which included cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction, epilepsy, encephalopathy, dementia, anxiety disorder and dysphagia following cerebral infarction. RI#14 was admitted to hospice services at the facility on February 7, 2025 (less

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 64	A 621		

than 2 months after admission to the facility) and passed away at the facility on March 16, 2025 (3 months after admission to the facility).

Review of RI#14's facility record, on March 19, 2025, and interviews with facility staff revealed the following information. RI#14 required a mechanical soft diet and usually had to be fed. RI#14 had speech therapy services to evaluate and treat in December 2024 due to coughing with swallowing. RI#14 was confined to a wheelchair and used a geriatric chair for mobility. RI#14 frequently resisted care. RI#14 required extensive assistance with transfers including two staff members. RI#14 required repositioning in the chair or bed. RI#14 was incontinent of bowel and bladder and required staff to provide incontinence care. Due to RI#14's history of multiple falls, the following Fall Interventions were documented on RI#14's facility care plan: "floor mat...use body pillow to define edges of bed...bed to wall...monitor resident for being in center of bed...1:1 sitter".

During a tour of the facility with EI#3, on March 17, 2025, the surveyors observed two containers of Thickit on a shelf in RI#14's room where RI#14's possessions remained. Thickit is used to thicken liquids when an individual has difficulty swallowing and is at risk for choking. The use of Thickit is considered skilled care due to the extreme risk of choking in individuals who require the Thickit for swallowing liquids. When questioned as to why the Thickit was in RI#14's room, facility nurses stated they (facility nurses) did not use the Thickit for RI#14 but the family may have brought it and used it for RI#14's liquids.

The surveyors requested all assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 621	Continued From page 65 including PSMS and Behavior Screenings for RI#14 from EI#2 on March 19, 2025 and again on March 20, 2025. The only PSMS score provided to the surveyors was completed on December 12, 2024, the date RI#14 was admitted to the facility. The Total Score on RI#14's PSMS was 17. This score did not match the documentation of RI#14's decline in condition. Although a Comprehensive Assessment was documented for RI#14 on February 7, 2025, the date RI#14 was admitted to hospice services, no PSMS score was completed for RI#14 on that date. RI#14 used a geriatric chair to provide support with sitting which could not be provided in a standard wheelchair, had difficulty swallowing with coughing during meals, had multiple falls and required the use of physical restraints as well as a 1:1 sitter in an attempt to prevent further falls. RI#14 likely did not qualify for retention in the SCALF but was retained at the facility until he/she passed away.	A 621		
A 702	420-5-20-.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	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 66	A 702		

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 solution shall be used in accordance with the manufacturers' 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 its equivalent or 30 seconds 12.5 ppm of iodine or the amount of time specified 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 67 (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop shall be stored in a holder inside the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight 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 backflow, 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 nor 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 maintain 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	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 68 consumed or discarded by that date, which is no more than three days from the date is was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 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 so that food is not contaminated in transport and foods that are transported are held and served at the appropriate temperature at all times. 8. Hot food shall be maintained at a minimum temperature of 135 degrees Fahrenheit and cold foods at a maximum temperature of 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.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 69 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. 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.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 70 (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 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	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 71 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 observations and interviews, the facility failed to protect food from contamination and failed to ensure dishes were properly sanitized. Findings: Dishwasher Gauge/Dish Sanitization During a kitchen tour with EI#5 (Dietary Director), on March 19, 2025 at approximately 1:40 PM, the surveyors observed the following. The surveyors asked to see the dishwasher during a rinse cycle. During the first rinse cycle the temperature gauge never moved and was at 110 degrees Fahrenheit the entire rinse cycle. The surveyors requested to see another rinse cycle and the temperature gauge never displayed a temperature higher than 118 degrees Fahrenheit. EI#5 stated that the company responsible for servicing the dishwasher just came and did not advise EI#5 of any malfunctions. EI#5 called the company while the surveyors were still performing the tour to request further servicing. Brownies During a kitchen tour with EI#5, on March 19, 2025 at approximately 1:40 PM, the surveyors observed the following. There was a multi-rack system which contained a pan of brownies that were not covered leaving them susceptible for food contamination.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 702	Continued From page 72 During an interview after the kitchen tour, EI#5 agreed with the surveyors' findings.	A 702		
A 703	420-5-20-.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 service area and shall be kept on file for the	A 703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 703	Continued From page 73 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 provide less than 14 hours between the evening and breakfast meals. Findings: During a facility tour on March 17, 2025, the following was observed. The meal times were posted outside the dining room. The times posted were 8:00 AM for breakfast, 12:00 PM for lunch, and 5:00 PM for dinner, leaving 15 hours between the dinner and breakfast meals. During an interview on March 20, 2025, EI#1 agreed with the surveyors' findings.	A 703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	420-5-20-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows, which prevent the entrance of rain or dust during inclement weather. (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area, and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Group homes with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial	A 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	Continued From page 75 exhaust hood system. (f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory with a soap dispenser and disposable towels, and shall be well lighted and ventilated. (g) Hand washing Facilities. Each Group and Congregate specialty care assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. (h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods, shall be provided Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be provided with thermometers. All refrigerators shall be kept clean. (i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used. (j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used	A 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	Continued From page 76	A 804		

for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area.

(k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc.

(l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc.

(m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use.

(n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room.

(o) Equipment. Minimum equipment in the kitchen shall include the following:

1. Range. In a Group specialty care assisted living facility, a residential use range is permitted. A Congregate specialty care assisted living facility shall have a heavy duty range suitable for institutional use with double oven, or equivalent.

2. Refrigerator. A Group specialty care assisted living facility may use a residential refrigerator. A Congregate specialty care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	Continued From page 77	A 804		

assisted living facility shall have a heavy-duty refrigerator suitable for institutional use.

3. Fire extinguisher. Five-pound type BC for residential hoods and K type for commercial hoods.

4. Dishwashing. The dishwashing equipment for Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system.

5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities.

6. Garbage cans with cover.

(p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination.

(q) Dining Room.

1. A resident dining room, or rooms, shall be provided which is large enough to seat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	Continued From page 78 not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be of the automatic type. This Rule is not met as evidenced by: Based on observations and interviews, the facility's food service area and kitchen were not properly maintained and clean. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received two complaints which alleged the kitchen was dirty and not properly maintained. The surveyors were able to substantiate these complaints during the onsite survey. Food Warmer During a kitchen tour with EI#5 (Dietary Director), on March 19, 2025 at approximately 1:40 PM, the surveyors observed the following. The food warmer was filthy and in the need of cleaning. EI#5 stated he had cleaned the food warmer multiple times, but stated it was so old it did not	A 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 804	Continued From page 79 come clean. Kitchen Lights During a kitchen tour with EI#5, on March 19, 2025, at approximately 1:40 PM, the surveyors observed the following. The kitchen was very dark and during a dishwasher rinse test the surveyor had to use a phone flashlight to see the temperature gauge. Also, there were lights that were not working with no covers present. EI#5 stated some new kitchen lights had been requested but had not been provided. During an interview with EI#1 on March 20, 2024, he/she agreed with the surveyors' findings.	A 804		
A 901	420-5-20-.09 (1) (2) Laundry. (1) General. (a) Direction and Supervision. Responsibility for laundry services shall be assigned to an employee. (b) Linen. Linens shall be handled, stored, processed, and transported in a manner consistent with generally accepted infection control practices. (2) Location and Space Requirements. (a) Each specialty care assisted living facility shall have laundering facilities unless commercial laundries are used. An on-site laundry shall be located in a specifically designated area, and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material. Laundry rooms shall	A 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 901	Continued From page 80	A 901		

not open directly into resident rooms or food service areas. Domestic washers and dryers which are for the exclusive use of residents may be provided in resident areas, provided they are installed in such a manner that they do not cause a sanitation problem or offensive odors.

(b) Each specialty care assisted living facility shall have a system in place to keep clean linen and dirty linen separated and to prevent the re-use of dirty linen before it is cleaned. Dirty linens and clothing shall not be stored, even temporarily, in the area set aside for clean linen.

(c) Ventilation of Laundry. Provisions shall be made for proper mechanical ventilation of the laundry, if located within the specialty care assisted living facility. Provisions shall also be made to prevent the re-circulation of air in commercial equipment laundries into heating and air conditioning systems outside the laundry area.

(d) Lint Traps. Adequate, effective, and clean lint traps shall be used in all dryers.

This Rule is not met as evidenced by:
Based on observations and interview, the facility laundry room was not properly maintained.

Findings:

During a tour of the facility with EI#3, on March 17, 2025, the surveyors observed the following in the Laundry Room. A very heavy buildup of lint was present in the lint traps under both dryers. Lint was also noted behind both dryers on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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 901	Continued From page 81 floor and on vents. EI#17 was working in the Laundry Room and stated she (EI#17) emptied the lint traps once a day at the end of her shift.	A 901		
A1001	420-5-20-.10 (1) Sanitation and Housekeeping. (1) Sanitation. (a) Water Supply. 1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department. 2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit. (b) Disposal of Liquid and Human Wastes. 1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped. 2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.	A1001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1001	Continued From page 82 3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department. (c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions, which may create a health, safety, or sanitation hazard. (d) Control of Insects, Rodents, and other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests. (e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toiletry articles. The use of a common towel and common bar soap is prohibited. (f) Garbage Disposal. 1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent	A1001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1001	Continued From page 83	A1001		

intervals and shall be thoroughly cleaned and aired before using again.

2. Garbage and waste shall be disposed of in accordance with local and state regulations.

(g) Control of Odors. The facility shall be free of objectionable odors.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to keep the premises neat and clean. In addition, odors were present inside and outside the building.

THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION.

Findings:

Premises

During a tour of the exterior of the building and grounds on March 19, 2025, the surveyors observed the following. The vinyl siding was in need of cleaning. There was a heavy buildup of spiderwebs inside and around the screens on the windows. Rugs were hanging over the wooden fence on the right side of the building. Sheets were piled on the ground inside the wooden fence on the right side of the building and there was a strong foul odor in that area. The fans in the courtyard area were in need of cleaning. On the right side of the building near the dumpster and behind the dumpster wall was rotted furniture, trash, rotten wood, floor mats, garbage cans, gas can, countertop, storage rack and old chairs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1001	Continued From page 84 Along the back side of the privacy fence behind the shrubbery to the right side of the building were numerous cans and bottles. The gutters were in need of cleaning. Upon entering the gate to the wooden fenced area on the right side of the building, the fence running along the right side inside the gate was rotten and had a gap that extended up to one foot on the bottom due to the wood being rotted out. EI#4 explained that the property was in need of spring cleaning. EI#1 also explained that the residents of the apartments next door added to the trash and items left along the fence and around the dumpster. Odors The Alabama Department of Public Health received a complaint which alleged there were odors in the facility. The surveyors were able to substantiate this complaint upon entry to the facility. Upon entering the facility, on March 17, 2025, the surveyors immediately noticed urine odors which extended throughout the facility in hallways, common areas and resident rooms. As noted above, odors were also present outside on the right side of the building. EI#1 explained that it was hard to prevent odors.	A1001		
A1002	420-5-20-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, decent, sanitary, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of	A1002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1002	Continued From page 85 housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials	A1002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1002	Continued From page 86 such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observations and interviews, cleaning supplies and flammable materials were not secured. In addition, a sanitary and comfortable environment was not maintained throughout the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: Cleaning Supplies/Flammable Materials During a facility tour with EI#3, on March 17, 2025 at approximately 1:10 PM, the following observations were made. Room 13 had Clorox/Lysol wipes. Room 18 had odorban disinfectant. At the desk area outside Room 78 was vinegar and Clorox cleanup. In the bathroom medicine cabinet of Room 60 was a bottle of alcohol and wound cleanser. In the cabinet under the bathroom sink of Room 36 was Scrubbing Bubbles cleaner. In the cabinet under the bathroom sink of Room 20 was laundry detergent. A can of lighter fluid was noted in the gazebo in the facility courtyard which was	A1002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1002	Continued From page 87	A1002		

accessible to all residents. All cleaning supplies in resident rooms were not secured by the facility which put all 67 residents in harms way. On the morning of March 18, 2025, the surveyors observed EI#1 removing unsecured items from residents' rooms.

Sanitary and Comfortable Environment

The Alabama Department of Public Health received multiple complaints which alleged the facility was not kept clean. The surveyors were able to substantiate this complaint during the onsite survey.

During a tour of the facility with EI#3, on March 17, 2025, the following observations were made. Cracks were noted across the ceilings of multiple resident rooms. The ceiling vents in bathrooms of multiple resident rooms were dusty and dirty. A live roach jumped out of the medicine cabinet in resident room 60. A brown substance was noted on the wall beside the toilet and beside the shower in resident room 60. There was no knob on the closet door in resident room 60. In resident room 54, the floor was very sticky and there was a banana peel on the floor in the corner just inside the entrance. Also, there was a brown substance on the bathroom door as well as on the quilt on the bed. Spider webs were noted on the ceilings in multiple resident rooms. In resident room 27, there was a brown substance on the bathroom countertop and sink as well as on the shower curtain and floor in the bathroom. A strong foul odor was noted in this room. At the desk areas outside resident room 28, there was trash on the floor. Multiple resident rooms were in need of sweeping. The closet door was off track in resident room 5. Handrails in the hallways were dirty in areas and trash was found between the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1002	Continued From page 88 rails and the walls. On the morning of March 18, 2025, EI#1 made rounds to resident rooms and made arrangements for these issues to be addressed.	A1002		
A1101	420-5-20-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All specialty care assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1101	Continued From page 89 wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1101	Continued From page 90 next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and Testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to conduct and document fire drills monthly and quarterly on each shift. THIS DEFICIENCY WAS CITED AS A RESULT OF A COMPLAINT INVESTIGATION. Findings: The Alabama Department of Public Health received a complaint which alleged fire drills were not conducted timely. Surveyors were able to substantiate this complaint during the onsite survey. Review of facility fire drill reports, provided by EI#4 on March 19, 2025, revealed the following information. No fire drill was documented in April 2024. In addition, fire drills were not documented quarterly on each shift during the first quarter (January-March) 2024, second quarter (April-June) 2024 and fourth quarter (October-December) 2024. EI#4 stated the fire drills had been completed but agreed the documentation was not provided.	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1206	Continued From page 91	A1206		
A1206	420-5-20-.12 (8) Physical Environment (8) Additional Requirements for Specialty Care Assisted Living Facilities. (a) Facilities shall be certified and licensed for housing residents with dementia, and must comply with these special requirements for the physical plant. Facilities should confirm local code requirements, which may vary from those indicated below. (b) Additional Smoke Detection. Smoke detectors (electrical or system type) shall be provided in the sleeping rooms and any bedroom suite sitting areas, which house dementia residents. These detectors shall initiate at least a local alarm or supervisory signal, through the fire alarm system or call system. (c) Windows in specialty care facilities may have devices which prevent opening of the window. (d) Areas to Wander and Secure Perimeter. 1. Each facility shall have a secure boundary or perimeter to safely accommodate residents in all aspects of its physical plant. Exterior building walls and doors, and walled or fenced outdoor areas may form this boundary. Such walls or fences shall be at least six feet high. 2. Each walled or fenced area shall have at least one gate, located along the discharge path of travel from the building egress doors to the public way. Gates shall be readily	A1206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1206	Continued From page 92 unlockable from either side by the staff or by automatic means. "Automatic means" shall be in the same manner as locked or delayed-egress exit doors. 3. If the facility's emergency plan utilizes fenced or walled outdoor spaces as refuge areas for containment of residents, each refuge area shall be of sufficient size to accommodate all occupants at a distance of not less than 50 feet from the building while providing a net area of 15 square feet per person. A gate shall be located within this refuge area. 4. If the facility's emergency plan uses the fenced or walled outdoor spaces merely as areas that are immediately passed through and exited, not as refuge areas for containment of residents, there is no size or area requirement for the fenced or walled spaces. 5. An outdoor courtyard, which is completely surrounded by the building, must have at least two separate doorways, located remotely from each other, leading into separate smoke compartments of the building. (e) Locking of Exit Doors. Locks on exit doors of each specialty care assisted living facility, if installed, shall be electrical locked or electrical delayed-egress locking devices. Buildings shall be protected throughout by an approved supervised automatic sprinkler system connected to the fire alarm system. 1. Delayed-egress locks must comply with the requirements for "Special Locking Arrangements" found in NFPA 101 Life Safety Code.	A1206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1206	Continued From page 93 2. Electrically locked doors shall comply with the following: (i) A control panel shall be provided at one or more stations with the capability to remotely unlock all exit doors, simultaneously. Locks may be arranged to unlock in Specialty Care compartments based on a zoning concept, where each zone is a rated fire or smoke compartment and the locks on all egress doors unlock within the alarmed zone or compartment. This zoning concept is permitted to apply to automatic functions required by the Life Safety Code. (ii) A key, code, or card release switch shall be provided inside the facility at each locked door, which shall override the locking system to allow exiting from the compartment or building. (iii) All locks shall release automatically upon activation of the facility fire detection, or fire sprinkler system, or upon disablement of the fire alarm system. (iv) Locks shall release automatically upon loss of electric power controlling the lock. (v) The facility shall provide the residents sponsors with adequate information about the facility's door locking arrangements. (vi) The facility shall assure, at least monthly, that locked or delayed-egress exit doors function properly, in accordance with required fire safety provisions.	A1206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P3701	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR GLEN ALZHEIMER'S SPECIAL CARE CENTER	570 SOUTHLAND DRIVE BIRMINGHAM, AL 35226

(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
A1206	Continued From page 94 This Rule is not met as evidenced by: Based on observations and interview, the facility failed to provide smoke detectors in residents' bedroom areas. Findings: During a facility tour with EI#3 on March 17, 2025 at approximately 1:10 PM, the following observations were made. The surveyor noted resident rooms 9, 10 and 24 did not have any smoke detectors. During an interview with EI#1 and EI#4, both agreed with the surveyors' findings but advised EI#4 had been painting and that was the reason the smoke detectors were missing. CONNIE CHERRY, REGISTERED NURSE TROY BLACK, REGISTERED NURSE	A1206		