

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P4917	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CARILLON OAKS MOBILE	STREET ADDRESS, CITY, STATE, ZIP CODE 5461 KOOIMAN ROAD THEODORE, AL 36582
---	--

(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	<p>Initial Comments</p> <p>On October 15, 2025, an unannounced licensure survey was conducted for this 48 bed Specialty Care Assisted Living Facility (SCALF) with a census of 25.</p> <p>Two complaints were investigated during this survey. Complaints 20240508002 and 20230815018 were unsubstantiated.</p> <p>The facility was found to be in substantial compliance 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. No deficiencies were cited.</p> <p>THERESA HARRISON, REGISTERED NURSE</p>	A 000		

Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------