

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: P5107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRY COTTAGE HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 SYLVEST DRIVE, BUILDING 100 MONTGOMERY, AL 36117
--	--

(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 August 27, 2024, an unannounced complaint investigation was conducted for this 16 bed Specialty Care Assisted Living Facility (SCALF) with a census of 14.</p> <p>There were three (3) complaints investigated during this survey. LC#20240822023, LC#20240701005 and LC#20240801008 were all received from the same complainant and were investigated during the onsite survey. No deficiencies were cited as a result of the complaint investigations.</p> <p>CONNIE CHERRY, REGISTERED NURSE</p>	A 000		

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