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 _____	R-C 05/28/2026

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 May 28, 2026, a probational licensure follow up survey was conducted for this 90 bed Specialty Care Assisted Living Facility (SCALF) with a census of 40. There were three (3) complaints investigated during this survey. LC#20260217009, LC#20250917006 and LC#20250416002 were not substantiated. There were no 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 residents and require a plan of correction.	A 000		
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	A 508	**Deficiency: A 508** **Regulation:** 420-5-20-.05(3)(h), Records and Reports — Incident Investigation **Cited Concern:** Failure to report incidents timely to the ADPH Online Incident Reporting System. **Corrective Action for Identified Residents/ Examples** The Administrator and Health Services Director (HSD) confirmed that the incidents cited in the Statement of Deficiencies (SOD) had been submitted to ADPH OIRS as indicated. Based on this, no further corrective action is required related to the identified reports.	05/28/2026

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A 508	Continued From page 1 unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury 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	A 508	Continued from Page 1 **Identification of Other Residents/Concerns** The Administrator and HSD reviewed incident reports and incident logs to identify any additional reportable incidents that may not have been submitted timely. No additional concerns were identified. **Measures to Prevent Recurrence** The Administrator provided education to the AHSD and HSD regarding reportable incidents, including requirements for immediate notification to the Administrator or designee, 24-hour OIRS reporting, and completion of incident investigations within 72 hours. All staff will be re-educated on reportable incidents, immediate notification of the AHSD, HSD, Administrator, or designee, 24-hour OIRS reporting requirements, and 72-hour incident investigation requirements by the AHSD or HSD. The AHSD or designee will assist with incident tracking and OIRS submission. A reportable incident tracking log has been implemented. Completion date: 6/12/26 **Monitoring** The Administrator or designee will review the incident tracking log and OIRS submission confirmations weekly for 4 weeks starting on 6/15/2026, then monthly moving forward. Any concerns will be corrected immediately. Documentation will be maintained in the Compliance binder in Administrator's office.	05/28/2026 06/10/2026 06/15/2026 06/12/2026 06/15/2026

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A 508	Continued From page 2 Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or 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	A 508		

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A 508	Continued From page 3 incident occurred. (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	A 508		

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A 508	Continued From page 4 connection with the investigation. (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.	A 508		

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A 508	Continued From page 5 (iv) 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. (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	A 508		

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A 508	Continued From page 6 the following: (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		

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A 508	Continued From page 7	A 508		

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

Findings:

Review of the ADPH OIRS on May 27, 2026 revealed the following incidents which were reported by the facility greater than 24 hours after the incident occurred:

On May 21, 2026 a resident fall occurred at 4:35 AM and was reported on May 22, 2026 at 3:41 PM;
On May 15, 2026 a resident fall occurred at 7:15 AM and was reported on May 19, 2026 at 7:31 PM;
On March 21, 2026 a resident fall occurred at 10:20 PM and was reported on March 23, 2026 at 4:28 PM;
On April 30, 2026 a resident injury occurred at 12:25 PM and was reported on May 2, 2026 at 7:42 PM;
On April 7, 2026 a resident fall occurred at 11:42 PM and was reported on April 9, 2026 at 3:48 PM;
On February 28, 2026 a resident fall occurred at 9:20 AM and was reported on March 2, 2026 at 3:08 PM;
On February 28, 2026 a resident fall occurred at 7:15 AM and was reported on March 2, 2026 at 3:01 PM;
On November 21, 2025 a resident fall occurred at 2:15 PM and was reported on November 25, 2025 at 1:22 PM;

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A 508	Continued From page 8 On October 8, 2025 a suspected abuse of resident incident occurred at 8:32 PM and was reported on October 10, 2025 at 3:36 PM. On May 27, 2026 the late incident reports were discussed with Employee Identifier (EI)#2 who agreed that some incidents had not been reported timely. EI#2 added that an Assistant Health Services Director had been hired and would assist with reporting incidents to ADPH to ensure the incidents are reported timely in the future.	A 508		
A1203	420-5-20-.12 (5) Physical Environment. (5) General Building Requirements - Group and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.	A1203	**Deficiency: A 1203** **Regulation:** 420-5-20-.12(5), Physical Environment — General Building Requirements **Cited Concern:** Failure to keep the interior and exterior of the building clean, orderly, and in good repair, and failure to ensure a usable call system was provided for each resident. **Corrective Action for Identified Residents/ Examples** The Administrator and Maintenance Director reviewed the cited physical environment and call system concerns. Immediate corrections were made, including clearing the blocked egress area, replacing the broken faucet mount, repairing wall holes, repairing the light fixture, ceiling cracks, and installing/testing call systems in the identified resident rooms. The following cited physical environment concerns have also been corrected by the Maintenance Director and third-party vendor, presence of algae/ moss growth, exposed wiring in electrical conduit box, presence of rotten wood on framing, and uneven sidewalk.	05/27/2026 06/05/2026

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A1203	Continued From page 9 (d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length 16 mesh screens. Screen doors shall be equipped with self-closing devices. (e) Emergency Lighting. 1. All specialty care assisted living facilities shall provide an emergency artificial lighting system to adequately illuminate halls, corridors, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces. 2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes. (f) Floors. 1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish. 2. Any differences in floor levels shall not prevent a resident from navigating safely throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall	A1203	Continued from Page 9 Remaining cited repairs, replacement of window screens, were placed on the maintenance corrective action log and assigned for completion. **Identification of Other Residents/Concerns** The Maintenance Director completed a facility-wide environmental review of resident rooms, bathrooms, common areas, exterior areas, exits, sidewalks, windows, lighting, ceilings, walls, and call systems. Any additional concerns identified were added to the maintenance log for correction. **Measures to Prevent Recurrence** The Administrator provided re-education to the Maintenance Director regarding keeping the interior and exterior of the building clean, orderly, and in good repair. The facility implemented routine environmental rounds and call system checks. Staff were re-educated to report maintenance concerns, blocked exits, broken fixtures, lighting issues, wall or ceiling damage, trip hazards, and call system concerns immediately. The Maintenance Director or Designee will track repairs through the maintenance log until completed. **Monitoring** The Maintenance Director or designee will complete weekly environmental rounds and call system audits for 8 weeks starting on 6/15/2026, then monthly moving forward. The Administrator or designee will review the maintenance log and audit results weekly for 8 weeks starting on 6/15/2026, then moving forward monthly. Documentation will be maintained in the Compliance binder in Administrator's office. Sarah Curatella 06/11/2026	06/15/2026 06/15/2026 06/10/2026 06/15/2026 06/15/2026 06/15/2026

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be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. Windows in specialty care facilities may have devices which prevent full opening of the window.

(i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes.

(j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at
30 - 36 inches above the floor and returned to the wall at each end.

(k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purposes. All walls and doors under stairs shall meet the same fire rating as the stairwell.

(l) Doors.

1. In each new specialty care assisted living facility, doors of resident bathrooms connected to resident bedroom shall swing into the bedroom.

2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at a central location.

3. Resident bedroom and other exit

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A1203	Continued From page 11	A1203		

access doors in specialty care assisted living facility shall be at least three feet wide.

4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other exterior egress doors may be arranged to prevent free and unhindered egress from specialty care assisted living facilities, in accordance with the Special Requirements portion of this section.

5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down.

(m) Ventilation. The building shall be well ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility.

(n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need.

1. Each fire extinguisher shall receive an annual inspection with maintenance, and recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative,

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day, month, and year of maintenance.

2. A visual inspection of each fire extinguisher shall be conducted monthly by a designated staff of the facility and documented on the attached extinguisher tag by the designated staff person.

(o) Call System. A central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard.

(p) Manufactured homes/mobile homes are not permitted.

(q) Fireplaces and inserts shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens or doors.

(r) Exit marking. In all facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.

(s) Heating, Lighting, and other Service Equipment.

1. Central or individual room gas

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	P3701	A. BUILDING: _____ B. WING _____	R-C 05/28/2026

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

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heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation.

2. Open flame and portable heaters are prohibited in specialty care assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules.

3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all specialty care assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to to keep the interior and exterior of the building clean, orderly and in good repair. In addition, a call system was not provided for each resident as required.

Findings:

Algae/Moss Growth:

On May 26, 2026 at approximately 9:42 AM the surveyor observed during an outside tour of the building that the east side of the front of the building had an overgrowth of green moss/algae along the roof edges extending approximately 36 inches toward the center peak of the roof line.

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A1203	Continued From page 14 This growth was also observed extending over the gutters lining the roof line. It was further observed that the two dog house(s) roof soffit areas were rotted at the point where the dog house soffit connected to the roof surface permitting possible infiltration of insect/pests into the roof areas. EI#1, Administrator, concurred with the surveyor's observations of the facility tour that these were deficient practices of maintaining good repair of the building. Electrical Conduit Box: During the same tour of the building the surveyor observed that the front northeast corner of the roof peak contained an electrical conduit box that did not have a cover, exposing the wiring contained in it to the environment. EI#1 concurred with the surveyor's observations of the facility tour that this was a deficient practice of maintaining good repair of the building. Window Screening: On the north side of the building six (6) of the eighteen (18) window screens were torn and required maintenance. EI#1 concurred with the surveyor observations of the facility tour that this was a deficient practice of maintaining good repair of the building. Rotten Window Framing: In the courtyard of the facility the surveyor noted that two window frames were rotted and required repair. The window facing the common room and the window facing the dining area were noted to have rotten framing along the bottom edge of the window frames. EI#1 concurred with the surveyor's observations of the facility tour that this	A1203		

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A1203	Continued From page 15 was a deficient practice of maintaining good repair of the building. Sidewalk: On the north side of the building the surveyor noted that the sidewalk was unleveled, damaged and cracked posing a tripping hazard to any resident utilizing the walk. EI#1 concurred with the surveyor's observations of the facility tour that this was a deficient practice of maintaining good repair of the building. Exterior Egress Doors: On the northeast corner of the building the surveyor noted during the facility tour that the exit egress door was blocked by the storage of a popcorn machine, lighting fixtures and miscellaneous resident furniture items (lamps, lamp shades, etc.) on the concrete outside the exit door. This presented a fire evacuation hazard to the residents. EI#1 was notified of the condition and stated she (EI#1) was not aware but immediately instructed employees to clear the egress during the survey. Faucet Mounting: On the morning of May 26, 2026 during a tour of the interior building accompanied by EI#5, Maintenance Director, the surveyor observed that in room 65, the bathroom sink faucet mounting had broken and the faucet was dislodged from it's mounting. EI#5 concurred with the surveyor's observation, stating it had not been reported to maintenance and immediately had maintenance personnel replace the faucet during the survey. Holes in the Walls:	A1203		

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A1203	Continued From page 16 During the accompanied tour of the interior building the surveyor noted that the area behind the toilets in rooms 25 and 30 had holes in the walls. The holes were approximately 4 x 6 inches behind the base of the toilet under the tank that had not been closed by the contractor performing repairs. EI#5 stated he (EI#5) was not aware that the work had not been completed and immediately had maintenance personnel take appropriate action to repair the holes during the survey. Cracked Ceilings: The surveyor observed that twelve 12 rooms had cracked ceilings and required repair. The following rooms had cracked ceilings: 3, 25, 26, 27A/B, 28A/B, 36, 42, 46, 62, 66, 78 and 84. EI#5 stated that it was a constant work effort to repair the cracks in the ceilings due to the age of the building. EI#5 had maintenance personnel immediately take appropriate action to repair ceiling cracks during the survey. Lighting: During the interior tour of building the surveyors observed that the room utilized as the resident supply storage room did not have adequate lighting. The four tube florescent light fixture was not functional during the tour. EI #5, stated that he (EI#5) was not aware the fixture was inoperable and immediately assigned maintenance personnel to repair the light fixture during the survey. Call System During the tour of the facility's interior with EI#5	A1203		

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A1203	Continued From page 17 on May 26, 2026, the surveyors observed that multiple residents' rooms did not contain a usable call system in the bedrooms and bathrooms. The residents' rooms which were affected were as follows: resident room 6B bedroom; resident room 11 bedroom and bathroom; resident room 13 bedroom and bathroom; resident room 34 bedroom and bathroom; resident room 37 bedroom; resident room 42 bedroom and bathroom. EI#5 stated that the facility's call system had been upgraded and he (EI#5) was unaware that the new system had not been placed in all residents' rooms. The call system was added to the residents' rooms which had not been upgraded on that same day and were checked by EI#5 to ensure proper functioning. On May 27, 2026, the surveyors observed the upgraded call system in the affected residents' rooms. CONNIE CHERRY, REGISTERED NURSE GREGORY ZEITLIN, REGISTERED NURSE	A1203		