

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D4704</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KEMP MEADOWS ASSISTED LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>652 TAHOE ROAD WINFIELD, AL 35594</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>An unannounced visit was made to this 16-bed Assisted Living Facility (ALF) on October 5, 2023 for a state licensure survey. There were no current residents of the facility.</p> <p>CONNIE CHERRY, REGISTERED NURSE</p>	A 000		

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