

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D2902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2024
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NAME OF PROVIDER OR SUPPLIER MORNINGVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 25TH STREET, NORTHWEST FAYETTE, AL 35555
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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>On October 16, 2024, an unannounced licensure survey was conducted for this 38 bed Assisted Living Facility (ALF) with a census of 28.</p> <p>There were no complaints investigated during this survey.</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 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. No deficiencies were cited.</p> <p>CONNIE CHERRY, REGISTERED NURSE</p>	A 000		

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