STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 January 7, 2026, an unannounced, inspection of care survey was conducted for this 33 bed Assisted Living Facility (ALF) with 21 residents. 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 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited require a plan of correction.	A 000		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed. 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 303	Continued From page 1	A 303		

6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character.

7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week.

8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement.

9. The facility administrator is responsible for ensuring that required training is provided to all staff.

10. The administrator shall ensure that residents who have health or safety needs beyond the capability of the facility will be safely transferred or discharged to an appropriate setting.

11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed.

12. The administrator shall ensure that plans of care for all residents are current and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 303	Continued From page 2 appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on interview and record review, EI#1, the Administrator, failed to adequately perform his duties. EI#1 failed to ensure previously cited deficient practices were corrected and compliance with SBOH rules for ALFs was maintained. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 24, 2025. Findings: The following deficient practices were cited during the onsite survey as a result of the administrator's inability or unwillingness to apply the SBOH rules in the day to day operations of the facility. 508 - Incidents were not reported to ADPH and were not investigated. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 24, 2025. 612 - An activity program to meet residents needs was not facilitated by staff. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 24, 2025. On the morning of January 7, 2026, EI#1 acknowledged the plan of correction submitted for the July 24, 2025, survey had not been	A 303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 303	Continued From page 3 followed. EI#1 claimed it was an oversight related to a preoccupation of personal origin.	A 303		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in an 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 unknown origin that was unusual or suspicious in nature such as 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.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 4 (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 of Alabama 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	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 5 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 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.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 6 (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 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	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 7	A 508		

incident:

(i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules.

(ii) Elopement by a resident.

(iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation 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. 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.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 8 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 of the Alabama Administrative Code Sec. 420-4-1-.04. shall 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 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system. 4. The report to the Department's Online Incident Reporting System shall include 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.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 9 (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report incidents to the ADPH as required and failed to properly investigate incidents of falls that resulted in requiring medical attention. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 24, 2025. Findings: On January 6, 2026, facility incident reports were reviewed and found that none of them had been reported to the Online Incident Reporting System (OIRS) by EI#1. There were no investigations conducted to try to determine the causes of the falls to prevent recurrence of each of these incidents. The following incidents had not been reported to the OIRS by the facility: RI#1 was admitted to the facility on March 2, 2023, with diagnoses which included traumatic brain injury and hemiplegia. RI#1 sustained a fall on December 21, 2025, and was sent to the hospital. This reportable incident was not reported to the ADPH OIRS or investigated.	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 10 RI#3 was admitted to the facility on June 29, 2022, with diagnoses which included chronic kidney disease, hypertension, anxiety and abnormality of gait. RI#3 sustained a fall on September 23, 2025, and was sent to the hospital. This reportable incident was not reported to the ADPH OIRS or investigated. RI#4 was admitted to the facility on April 18, 2024, with diagnoses which included chronic obstructive pulmonary disease (COPD) and heart disease. RI#4 sustained falls on September 1, 2025, and October 5, 2025 and was sent to the hospital each time. These reportable incidents were not reported to the ADPH OIRS or investigated. RI#5 was admitted to the facility on December 29, 2023, with diagnoses which included COPD, hypertension, hyperlipidemia and history of Cerebrovascular Accident (CVA). RI#5 sustained a fall on November 30, 2025, and was sent to the hospital. This reportable incident was not reported to the ADPH OIRS or investigated. RI#6 was admitted to the facility on January 28, 2025, with diagnoses which included hypertension, atrial fibrillation and abnormality of gait. RI#6 sustained a fall on August 15, 2025, and was subsequently hospitalized on August 17, 2025, with three broken ribs. This reportable incident was not reported to the ADPH OIRS or investigated. NOTE: The ADPH OIRS had not received any reportable incidents since the last survey on July 24, 2025. On the morning of January 7, 2026, EI#1 agreed each of the incidents named above should have been reported and investigated. EI#1 said he had	A 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 508	Continued From page 11 been distracted and pre-occupied, but acknowledged he should have followed the rules by reporting and investigating each incident.	A 508		
A 612	420-5-4-.06 (4) (c) (d) (e) (f) Care of Residents (c) The facility shall offer appropriate activity programs to each resident, maintaining supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to each resident. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to place and receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading mail out loud if requested to do so. (f) Appointments. Residents shall be	A 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 612	Continued From page 12 assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide an activity program to meet the needs of the residents. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON JULY 24, 2025. Findings: Observations were made on January 6-7, 2026, for implementation of the scheduled activities. None were facilitated by staff. On the morning of January 7, 2026, eight of eight residents present in the dining room reported there are no activities offered on a daily basis. Activities are usually offered approximately once every two weeks. Later on the morning of January 7, 2026, EI#3, a caregiver/manager, said activities should be offered daily. EI#3 said the purpose of an activity program was to get residents out to socialize, moving and just sitting in their rooms. EI#3 acknowledged the activity calendar was not being followed. On the morning of January 7, 2026, EI#2, the second Administrator, said she and EI#1 were responsible for ensuring residents are offered activities. EI#2 was asked why that was not done. EI#2 said she had tried to get residents to participate. Due to lack of participation, she had not ensured activities had been facilitated by staff. Later, on the morning of January 7, 2026, EI#1 was asked why residents were not being invited	A 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D2807	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LANDING	616 GAINES STREET ATTALLA, AL 35954

(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 612	Continued From page 13 to participate in activities. EI#1 said it was the lack of participation in the past. EI#1 said the reason bible study was not conducted on January 6, 2026, was because an outside resource person was not available. EI#1 acknowledged he should have had staff offer an alternate activity. EI#1 said he and EI#2 were responsible for ensuring an appropriate activity program was in place and the deficiency would be corrected. THERESA HARRISON, REGISTERED NURSE	A 612		