

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 September 15, 2025, an unannounced licensure survey was conducted for this eight (8) bed Assisted Living Facility (ALF) with a census of four (4).</p> <p>There were two (2) complaints investigated during this survey. LC#20250908006 and LC#20250421003 were unsubstantiated.</p> <p>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 (ALF). The deficiencies cited pose a risk or potential risk of harm to the residents and require a plan of correction.</p>	A 000		
A 302	<p>420-5-4-.03 (1) (e) Administration. Policies.</p> <p>The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:</p> <p>(i) Facility responsibility to protect all</p>	A 302		

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

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 302	<p>Continued From page 1</p> <p>residents from abuse, neglect, and exploitation.</p> <p>(ii) How allegations of abuse, neglect, and exploitation will be handled by the facility.</p> <p>(iii) Resident confidentiality.</p> <p>(iv) Admission and continued stay criteria.</p> <p>(v) Discharge criteria and notification procedures for residents and sponsors.</p> <p>(vi) Facility responsibility when a resident's personal belongings are lost.</p> <p>(vii) What services the facility is capable and not capable of providing.</p> <p>(viii) Medication management.</p> <p>(ix) Infection control.</p> <p>(x) Meal service, timing, menus and food preparation, storage, and handling.</p> <p>(xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness.</p> <p>(xii) Staffing and conduct of staff while on duty.</p> <p>(xiii) Oxygen administration and storage if used in the facility.</p> <p>(xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the</p>	A 302		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 302	<p>Continued From page 2</p> <p>guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address:</p> <p>(I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling.</p> <p>(II) The attire and cleanliness of staff members who prepare, handle, or serve food.</p> <p>(III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids.</p> <p>(IV) Food substitutions or alternatives.</p> <p>(V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.</p> <p>(VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food.</p> <p>(VII) Provision of necessary services to any resident requiring adaptive devices to eat.</p> <p>(VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs.</p> <p>(IX) Storage of food.</p>	A 302		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 302	<p>Continued From page 3</p> <p>(X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available.</p> <p>This Rule is not met as evidenced by: Based on observation, and interview the facility failed to ensure policies and procedures available to staff, residents, guardians, next of kin, sponsoring agency(ies), or representative payee(s).</p> <p>Findings:</p> <p>On the morning of September 15, 2025 during an interview with the Administrator designee, Employee Identifier (EI) #2 stated that the facility had policies and procedures but they were kept in the administrator's office. EI#2, the administrator designee stated EI#2 did not have access to the administrator's office where the files were secured. EI#2 stated that EI#2 was in charge in absence of the administrator, EI#1. EI#2 stated that EI#1 was out of state on a family emergency, attending a funeral of EI#1's family member. EI#2 stated EI#2 does not have access to the administrator's office and there were no additional copies of the policies and procedure in the facility.</p> <p>On the morning of September 16, 2025 during an interview with staff (EI#3) was asked does the facility have a policy and procedure manual. EI#3 stated that they do but it is kept in the administrator's office. EI#3 stated the staff does not have access to the administrator's office.</p>	A 302		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 405	Continued From page 4	A 405		
A 405	<p>420-5-4-.04 (6) Personnel.</p> <p>(6) Training.</p> <p>(a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below:</p> <ol style="list-style-type: none"> <li>1. State law and rules on assisted living facilities.</li> <li>2. Facility policies and procedures.</li> <li>3. Resident rights.</li> <li>4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire.</li> <li>5. Identifying and reporting abuse, neglect, and exploitation.</li> <li>6. Basic first aid.</li> <li>7. Advance directives.</li> <li>8. Protecting resident confidentiality.</li> <li>9. Resident fire and environment safety.</li> </ol>	A 405		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 405	<p>Continued From page 5</p> <p>10. Special needs of the elderly, mentally ill, and mentally retarded.</p> <p>11. Safety and nutritional needs of the elderly.</p> <p>12. Identifying signs and symptoms of dementia.</p> <p>(b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.</p> <p>(c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training.</p> <p>(d) Continuing Education. All staff must receive annual continuing education sufficient to</p>	A 405		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 405	<p>Continued From page 6</p> <p>remain knowledgeable of the training specified above.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide employee training records to the surveyor.</p> <p>Findings:</p> <p>On the afternoon of September 15, 2025, EI#2, administrator designee, was asked for the personnel files for EI#1, EI#2, EI#3, EI#4, EI#5, and EI#6. EI#2 stated the files were in the administrator's office and EI#2 did not have the key for that office. EI#2 stated she could not provide the requested records.</p> <p>EI#3 also stated that policies and procedure manual was kept in the administrator's office for the staff.</p>	A 405		
A 501	<p>420-5-4-.05 (1) Records and Reports.</p> <p>(1) General.</p> <p>(a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence.</p> <p>(b) All records and reports required by these rules shall be completed in a timely manner, and shall be maintained and filed in an orderly manner within the assisted living facility premises.</p>	A 501		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 501	<p>Continued From page 7</p> <p>(c) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access.</p> <p>(d) All facility records, including resident medical records, shall be made readily available for review and copying on demand by representatives of the State Board of Health upon request.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to make, readily available for review and copying, facility records by the surveyor.</p> <p>Findings:</p> <p>On the morning of September 15, 2025 the surveyor requested medical and administrative records of the four current residents of the facility. Only partial records were made available to the surveyor (Medication Administration Record (MAR), Care Plans, Monthly Assessment (MA)). Financial and administrative records were unavailable due to the staff not having access to the administrator office. The administrator designee, EI#2 stated that the requested records were located in the administrator's office and they did not have access to those resident records.</p>	A 501		
A 505	<p>420-5-4-.05 (3) (e) Records and Reports.</p> <p>(e) Financial Agreement.</p>	A 505		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 505	<p>Continued From page 8</p> <p>1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections.</p> <p>2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following:</p> <p>(i) A complete list of the facility's basic charges (room, board, laundry and personal care and services).</p> <p>(ii) The period covered by the financial agreement.</p> <p>(iii) A list of services not covered under basic charges and for which additional charges will be billed.</p> <p>(iv) The policy and procedures for refunds of any payments made in advance.</p> <p>(v) The provisions governing termination of the agreement by either party.</p> <p>(vi) The facility's bed-hold policy, procedures, and charges.</p> <p>(vii) Documentation that the resident and sponsor understand that the facility is not staffed</p>	A 505		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 505	<p>Continued From page 9</p> <p>and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than 90 days, that the resident will be discharged by the facility after prior written notice.</p> <p>(viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed.</p> <p>(ix) Signatures of both parties or authorized representatives.</p> <p>3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to ensure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant).</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to make, readily accessible, resident financial agreements to the surveyor during survey.</p>	A 505		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 505	Continued From page 10  Findings:  On the afternoon of September 15, 2025 the surveyor conducted a resident record review and observed that the residents' records did not contain financial agreements, completed resident inventory of effects form, residents' acknowledgement of transfer plans or complete residents' plans of care. The surveyor requested four residents' financial agreements for inspection. EI# 2 was asked for Resident Identifier (RI) #1, RI#2, RI#3 and RI#4 financial agreements. EI#2 the administrator designee stated EI#2 did not have access to the administrator's office where the files were secured.	A 505		
A 506	420-5-4-.05 (3) (f) Records and Reports.  (f) Inventory of Personal Effects.  1. Upon admission to the assisted living facility, all personal property of the resident with a value in excess of \$150, as well as any other property designated by the resident, shall be inventoried by the administrator or by a designee of the administrator in the presence of the resident.  2. All inventories shall be entered on an Inventory of Personal Effects Record. Inventory forms shall be signed by both the administrator, the resident, or if appropriate, the sponsor. One copy of the inventory shall be filed in the resident's individual file and one copy given to the resident or sponsor.  3. In the event the resident has no	A 506		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 506	<p>Continued From page 11</p> <p>personal effects, this fact shall be entered on the Inventory of Personal Effects Record.</p> <p>4. Amendments or adjustments shall be made on all copies of the Inventory of Personal Effects Record each time personal property valued in excess of \$150 is brought to the facility, or when personal property is brought to the facility and the resident or sponsor requests that it be added to the Inventory of Personal Effects Record, or when any item on the Inventory of Personal Effects Record is removed from the facility. All amendments shall be signed by the administrator and the resident or sponsor.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility did not have resident inventory of personal effects available to the surveyor.</p> <p>Findings: On the morning of September 15, 2025 during resident record review, it was found that the resident record did not contain an inventory of personal effects. EI#2 was interviewed that morning and EI#2 stated that the inventory is kept in the resident folders in the administrator's office. EI#2 stated EI#2 did not have access to the office and could not provide the inventories to the surveyor.</p>	A 506		
A 611	420-5-4-.06 (4) (a) (b) Care of Residents.  (4) Personal Care and Services. The	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 611	<p>Continued From page 12</p> <p>facility shall provide care and services consistent with community standards.</p> <p>(a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times.</p> <p>(b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated.</p> <p>1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following:</p> <p>2. A listing of the resident's individual needs or problems that require intervention by the facility.</p> <p>3. A listing of interventions provided by the facility to address the resident's identified</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 611	<p>Continued From page 13</p> <p>needs or problems.</p> <p>4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.</p> <p>5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.</p> <p>(i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested.</p> <p>(ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.</p> <p>(iii) Hair. Resident's hair shall be kept clean, neat, and well groomed.</p> <p>(iv) Manicure. Fingernails and toenails shall be kept clean and trimmed.</p> <p>(v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed.</p> <p>(vi) Personal Safety. Residents shall be provided assistance with personal safety.</p> <p>6. As changes in medication and</p>	A 611		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 611	<p>Continued From page 14</p> <p>personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a copy of the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider.</p> <p>Findings:</p> <p>On the afternoon of September 16, 2025 the surveyor requested to inspect the Home Health Plan of Care for RI #4. RI#4 had recent hernia surgery (September 2, 2025). Home Health Services had been ordered for physical therapy gait training and skilled nursing for surgical wound care. RI#4's resident record did not include the Home Health Care Plan. EI#2 stated EI#2 would contact the Home Health agency and get another copy as RI#4's son had removed the Home Health folder from the room.</p>	A 611		
A 614	<p>420-5-4-.06 (5)(f)(g)(6)(7)(a)-(i) Care of Residents.</p> <p>(f) A resident may self-manage his or her medications. For the purposes of these rules, self-manage shall mean the resident is capable of maintaining possession and control of his or her medications, who does maintain possession and control of his or her medications, and self-administers his or her medications without creating an unreasonable risk to health and</p>	A 614		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 614	<p>Continued From page 15</p> <p>safety.</p> <p>(g) A resident that cannot self-manage his or her own medication without creating an unreasonable risk to health and safety may be assisted with self-administration of medication by any assisted living facility staff, including staff members who hold no professional licensure provided:</p> <p>1. The resident can and does identify his or her name on the medication package and has a reasonable understanding of the unit dose packaging system in use by the facility such that the resident could protect himself or herself from medication errors when unit dose packages are brought to the resident by facility staff. The resident shall have the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use.</p> <p>(6) Assistance with self-administration of medication includes the following practices:</p> <p>(a) Reminding a resident that it is time to take a medication or medications, where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time, or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed.</p> <p>(b) Physically assisting a resident by opening or helping to open a container holding medications.</p> <p>(c) Offering liquids to a resident to assist that resident in ingesting oral medications.</p>	A 614		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 614	<p>Continued From page 16</p> <p>(d) Physically bringing a container of medication to a resident.</p> <p>(7) Assistance with self-administration of medications shall under no circumstances include any of the following practices:</p> <p>(a) Medication administration as defined in these rules.</p> <p>(b) Determining the amount of medication to be given. If a medication is not available in unit dose packaging, unlicensed facility staff may measure the prescribed amount of medication only under the direction and control of the resident, provided that the resident is capable of determining the amount of medication to be given.</p> <p>(c) Giving a resident injections of any kind.</p> <p>(d) Telling or reminding a resident that it is time to take a PRN, or as needed medication.</p> <p>(e) Placing medications in a feeding tube.</p> <p>(f) Giving enemas or suppositories.</p> <p>(g) Crushing or splitting medications, provided that a physician has ordered a specific medication to be crushed or split and the resident is capable of self-managing his or her own medication or the resident is capable of medication self-administration with assistance and would be capable of crushing or splitting his</p>	A 614		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 614	<p>Continued From page 17</p> <p>or her own medications but for limitations of mobility or dexterity, may be assisted with crushing or splitting medications by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.</p> <p>(h) Mixing medications with food or liquids, provided that a physician has ordered a medication to be mixed with food or liquid and the resident is capable of self-managing his or her own medications or the resident is capable of medication self-administration with assistance and would be capable of mixing his or her own medications with food or liquid but for limitations of mobility or dexterity, may be assisted with mixing medications with food or liquid by unlicensed staff so long as the assistance provided is under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.</p> <p>(i) Assisting with self-administration of eye drops, eardrops, nose drops, inhalers, nebulizers, or topical medications, provided that a resident who is capable of self-managing his or her own medication or a resident who is capable of medication self-administration with assistance and who would be capable of self-administration of his or her own medications but for limitations of mobility or dexterity, may be assisted with eye drops, ear drops, nose drops, inhalers, nebulizers, or topical medications by unlicensed facility staff so long as the assistance provided is</p>	A 614		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 614	<p>Continued From page 18</p> <p>under the total control and direction of the resident. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a resident the opportunity to demonstrate his or her ability to correctly utilize the unit dose package system at every opportunity for medication use.</p> <p>Findings:</p> <p>On the morning of September 16, 2025, during observation of morning medication pass, EI#6 was observed failing to provide the opportunity for RI#3 to demonstrate correct utilization of the unit dose package system. EI#6 had provided RI#3's medications in a cup marked with RI#3's name. RI#3 was not presented with the unit dose package to verify it was RI#3's correct medication and time of administration.</p>	A 614		
A 615	<p>420-5-4-.06 (7) (j) Care of Residents.</p> <p>(j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication</p>	A 615		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 615	<p>Continued From page 19</p> <p>assistance record shall include at least the following:</p> <ol style="list-style-type: none"> <li>1. The name of the resident to whom the medication was administered or assisted.</li> <li>2. The name of the medication administered or assisted.</li> <li>3. The dosage of the medication administered or assisted.</li> <li>4. The method of administration or assistance.</li> <li>5. The site of injection or application, if the medication was injected or applied.</li> <li>6. The date and time of the medication administration or assistance.</li> <li>7. Any adverse reaction to the medication.</li> <li>8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication.</li> </ol> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, medication assistance was not contemporaneously recorded.</p> <p>FINDINGS:</p> <p>On the morning of September 15, 2025 the surveyor interviewed the caregiver EI#2. EI#2</p>	A 615		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 615	<p>Continued From page 20</p> <p>was asked if EI#2 had completed morning medication assistance pass. EI#2 said yes. The surveyor then inspected the medication assistance record for RI#3 and noted that there were no initials for the medication scheduled at 0700 AM on the medication assistance record (MAR). Medication scheduled to be given were Cetirizine 10 mg tablet, Losartan 100 mg tablet, Pantoprazole 40 mg tablet, Meloxicam 15 mg tablet, Nystatin powder to affected area and Cimetidine 300 mg tablet which were not initialed on the MAR. The surveyor asked EI#2 why the MAR was not signed, EI#2 stated "oops, I must not of signed it." The surveyor asked EI#2 what is the policy for medication assistance procedure. EI#2 responded "you sign it (MAR) as you go". The surveyor asked to see the medication assistance policy, EI#2 stated the "policy book is in the administrator's office, I don't have a key for that office".</p> <p>On the morning of September 16, 2025 the surveyor observed EI#6 assist with medications and noted that EI#6 did not sign the MAR until after she assisted with all four residents. The surveyor asked what is the policy of the facility for documentation, EI#6 responded that you sign as you go. The surveyor asked why did you not do that? EI#6 did not respond to surveyor question.</p>	A 615		
A 702	<p>420-5-4-.07 (2) Food Service</p> <p>(2) Food Handling Procedures.</p> <p>(a) Dish and Utensils Washing, Disinfection, and Storage.</p> <p>1. Wash water shall be changed with sufficient frequency to avoid gross contamination,</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 21</p> <p>and final rinse water shall be kept clean and clear.</p> <p>2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods:</p> <p>(i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or</p> <p>(ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months.</p> <p>3. Dishes and utensils shall be allowed to air dry.</p> <p>4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 22</p> <p>such a way as to prevent contamination from hands and clothing.</p> <p>5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility.</p> <p>(b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin.</p> <p>(c) Protection of Food from Contamination.</p> <p>1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use.</p> <p>2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food.</p> <p>3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor.</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 23</p> <p>4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times.</p> <p>5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared.</p> <p>6. All food products shall be used by the manufacturer's indicated date or discarded.</p> <p>7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times.</p> <p>8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit.</p> <p>9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 24</p> <p>foods).</p> <p>10. Laundry shall not be brought through the food preparation or service area.</p> <p>(d) Storage and Service of Milk and Ice Cream.</p> <p>1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.</p> <p>2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is to be poured or drunk, will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident.</p> <p>3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses.</p> <p>(e) Kitchen Garbage and Trash Handling.</p> <p>1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 25</p> <p>garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals.</p> <p>2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse.</p> <p>(f) Employees' Cleanliness.</p> <p>1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food.</p> <p>2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room.</p> <p>3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use.</p> <p>(g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area.</p> <p>(h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors.</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 26</p> <p>(i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities.</p> <p>(j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods.</p> <p>(k) Laundering of clothing shall not be permitted in food preparation or service areas.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility staff failed to wear hair restraints and clean covering over clothing when engaged in handling, preparation and serving of food. Facility staff also failed to document results from the dishwashing machine sanitation requirements.</p> <p>Findings:</p> <p>On September 15, 2025 during the noon meal preparation it was observed that staff preparing, handling and serving food did not have hair restraints or a clean covering, covering clothing worn while having contact with residents. Both staff members on duty, EI#2 and EI#3 did not have hair restraints nor clean covering over the clothing worn while attending to and caring for residents while preparing, handling, and serving food.</p> <p>It was also observed that the food storage refrigerator and freezer did not have thermometers as required. EI#2 was asked why the refrigerator and freezer did not have</p>	A 702		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 702	<p>Continued From page 27</p> <p>thermometers, EI#2 stated "I will get some by the end of today". It was noted on September 16, 2025 kitchen storage tour that thermometers were in place in the refrigerator and freezer.</p> <p>On the morning of September 16, 2025 at approximately 0630 AM it was observed that EI#6 was preparing, handling and serving food without appropriate hair restraint and clean covering over clothes worn while attending to residents. EI#6 was asked by the surveyor what is the policy and procedure for serving food to residents? EI#6 stated nothing in response.</p> <p>On September 16, 2025 during inspection tour of facility kitchen it was observed that the facility did not record dishwashing sanitation results as required. The surveyor asked EI#2, how do you know that the dishwasher has sanitized the utensils as required. EI#2 stated we just run it in the dishwasher, let it air dry then store the utensils. We do not record anything that I know of. The surveyor pointed out on the cabinet the posted copy of the regulation and the procedure to follow. EI#2 stated that she would ask the administrator, EI#1 when EI#1 returned. On the same afternoon EI#5 was asked the same question and responded "we follow the procedure posted on the cabinet". There was no record or log of sanitization located by employees when surveyor requested the information.</p>	A 702		
A 703	<p>420-5-4-.07 (3) Food Service.</p> <p>(3) Dietary Service.</p> <p>(a) Number of Meals. No fewer than three meals shall be provided each 24 hours.</p>	A 703		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 703	<p>Continued From page 28</p> <p>Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents.</p> <p>(b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available.</p> <p>(c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs.</p> <p>(d) Alternate food selections or substitutes shall be made available to all residents.</p> <p>(e) A facility shall not obtain food from</p>	A 703		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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 703	<p>Continued From page 29</p> <p>charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals.</p> <p>(f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility did not have emergency non-perishable food and potable water in sufficient quantity to serve all residents for three (3) days as required.</p> <p>Findings:</p> <p>On the morning of September 15, 2025 during a tour of the facility it was observed that the non-perishable food quantity for an emergency was not designated. Potable emergency water quantity was insufficient of the required 12 gallons to be on hand. During an interview with EI#2 on the same morning, EI#2 stated that "I will let the administrator know, and get the required amount right away". EI#2 stated EI#2 was not aware that the facility had to have an emergency food and water designated for emergencies, but would make sure in the future there was the needed amount marked for emergencies only.</p>	A 703		
A1001	420-5-4-.10 (1) Sanitation and Housekeeping.	A1001		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1001	<p>Continued From page 30</p> <p>(1) Sanitation.</p> <p>(a) Water Supply.</p> <p>1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall meet the approval of the local County Health Department.</p> <p>2. Water under pressure of not less than 15 pounds per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water. Tubs, showers, sinks, lavatories, and other fixtures used by residents shall have hot water supplied. Hot water accessible to residents shall in no case exceed 110 degrees Fahrenheit.</p> <p>(b) Disposal of Liquid and Human Wastes.</p> <p>1. There shall be installed within the building a properly designed waste disposal system, connecting to all fixtures to which water under pressure is piped.</p> <p>2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed through trapped drains into a public sewer in localities where such system is available.</p> <p>3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the local County Health Department. The sewage disposal</p>	A1001		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1001	<p>Continued From page 31</p> <p>system shall be of a size and capacity based on the number of residents and personnel housed and employed in the institution. Where the sewage disposal system is installed at an existing facility prior to granting of a license, it shall be inspected and approved by the local County Health Department.</p> <p>(c) Premises. The premises shall be kept neat and clean. The property shall be free of rubbish, weeds, ponded water, or other conditions that may create a health, safety, or sanitation hazard.</p> <p>(d) Control of Insects, Rodents and Other Pests. Each facility shall be kept free of ants, flies, roaches, rodents, and other pests. Proper and lawful methods for their eradication or control shall be used. Droppings shall be evidence of infestation by pests.</p> <p>(e) Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, and toiletry articles. The use of a common towel and common bar soap is prohibited.</p> <p>(f) Garbage Disposal.</p> <p>1. Garbage must be kept in water-tight suitable containers with tight-fitting covers. Garbage containers must be emptied at frequent intervals and shall be thoroughly cleaned and aired before using again.</p> <p>2. Garbage and waste shall be disposed of in accordance with local and state</p>	A1001		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1001	<p>Continued From page 32 regulations.</p> <p>(g) Control of odors. The facility shall be free of objectionable odors.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain hot water temperature below 110 degree Fahrenheit.</p> <p>Findings:</p> <p>On the morning of September 15, 2025 it was observed that the water temperature in the Spa bath/shower was found to be 114.4 Fahrenheit degrees. EI#2 was present at time of checking temperature and stated EI#2 would let the maintenance person know to adjust it.</p>	A1001		
A1101	<p>420-5-4-.11 (1) Fire and Safety</p> <p>(1) General.</p> <p>(a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place.</p> <p>(b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the</p>	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1101	<p>Continued From page 33</p> <p>residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years.</p> <p>(c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs.</p> <p>(d) Roller latches are prohibited on doors separating corridors from adjacent spaces.</p> <p>(e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that:</p> <ol style="list-style-type: none"> <li>1. Minimizes leaks and spills.</li> <li>2. Adequately protects against inappropriate access.</li> <li>3. Complies with the requirements of the currently adopted Life Safety Code.</li> </ol> <p>(f) Fire Alarm and Sprinkler System.</p> <ol style="list-style-type: none"> <li>1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection</li> </ol>	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1101	<p>Continued From page 34</p> <p>system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements).</p> <p>2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously.</p> <p>3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, fire drills were not conducted, and written observations of the effectiveness of the fire drill plan were not assessed monthly, filed, or kept for at least three years as required. The facility was unable to provide sprinkler and fire alarm inspection reports.</p>	A1101		

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D2816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RIVERBEND ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>953 ALBERT RAINS BLVD GADSDEN, AL 35901</b>
--	---

(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
A1101	<p>Continued From page 35</p> <p>Findings:</p> <p>On the afternoon of September 15, 2025 the administrator designee EI#2 was asked for the fire sprinkler, fire alarm inspection reports and fire drill records. EI#2 stated that they were "locked in the administrator office" and "I don't have a key to that office". The facility could not provide the documentation of fire inspections, or fire drill evaluations at the time of survey.</p> <p>On the morning of September 16, 2025 interviews were conducted with all residents, RI#1, RI#2, RI#3, and RI#4, each resident reported that they could not recall having participated in a fire drill at the facility. On the afternoon of September 16, 2025, during conduction of a fire drill all residents participated correctly in performance of evacuation according to posted evacuation plan.</p> <p>GREGORY ZEITLIN, REGISTERED NURSE</p>	A1101		