

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D4519</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/13/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY COTTAGE HUNTSVILLE IVY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4200 CHRIS DRIVE HUNTSVILLE, AL 35802</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p><b>Initial Comments</b></p> <p>On September 13, 2022, an unannounced licensure survey was conducted for this 16 bed Assisted Living Facility with a census of eight (8).</p> <p>There were no complaints investigated during this survey.</p> <p>There were no deficiencies cited during this survey. The facility was found to be in substantial compliance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities (ALF).</p> <p>DEBRA FREEMAN, REGISTERED NURSE</p>	A 000		

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