

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>P4516</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/24/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADISON AT THE RANGE MEMORY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10803 COUNTY LINE ROAD MADISON, AL 35758</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 November 24, 2020, an unannounced survey was conducted to investigate self-reported incidences of COVID-19 disease outbreaks.</p> <p>This is a 42 bed Specialty Care Assisted Living Facility (SCALF) with a census of 30.</p> <p>No complaints were investigated during this survey. No deficiencies were cited during this survey.</p> <p>The facility was found to be in substantial compliance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities.</p> <p>DEBRA FREEMAN, REGISTERED NURSE</p>	A 000		

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