

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D5807	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2012
NAME OF PROVIDER OR SUPPLIER OAK CIRCLE ASSISTED LIVING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7690 AL HWY 144 RAGLAND, AL 35131		
(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 There no complaints investigated during the survey. This is a two bed family Assisted Living Facility with a census of two on December 12, 2012. There were no deficiencies cited during the survey. The facility's survey result is GREEN with a final score of 100.	A 000			

Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

HLVJ11

If continuation sheet 1 of 1