STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4502	A. BUILDING _____ B. WING _____	12/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE ASSIS LIV CENTE	4411 MCALLISTER DRIVE HUNTSVILLE, AL 35805

(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 December 1, 2007, a routine survey and complaint investigation was conducted. The following complaint was investigated during the survey: 25-2006 was not substantiated. This is a 17 bed congregate Assisted Living Facility with a census of ten on the survey date. The facility's survey result is Yellow with a final score of 80. A facility plan of correction for cited deficiencies was submitted and accepted.	A 000		

Health Care Facilities

TITLE (X6) DATE

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