Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D6105	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET INN	614 CHAFFEE STREET TALLADEGA, AL 35160

(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 were no complaints investigated during the survey. This is a 30 bed Assisted Living Facility with a census of 9 on the survey date. The facility's survey result is Yellow with a final score of 87. Deficiencies were cited during this survey for failure to operate the facility in accordance with the State Board of Health's (SBOH) Rules for Assisted Living Facilities (ALFs), Chapter 420-5-4, Administrative Code.	A 000		

Health Care Facilities

TITLE (X6) DATE

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