

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL21218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2009
NAME OF PROVIDER OR SUPPLIER UNLICENSED AT 416 EAST 22ND STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 416 EAST 22ND STREET BALTIMORE, MD 21218		
(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
E 000	<p>Initial Comments</p> <p>On July 1, 2009 an unannounced complaint survey was made to the above residence for the purpose of determining compliance with Comar 10.07.14. Survey activities included an attempted interview of one resident. Property owner was not available. Telephone conversation was made with the property owner and he agreed to meet us there on July 2, 2009.</p> <p>On July 2, 2009 a return visit was made. Survey activities include interview of property owner and interview of one border.</p> <p>Based on survey findings, the residence is not operating as an assisted living facility.</p>	E 000		

OHCQ

TITLE

(X6) DATE

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