

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AM000544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN ASSISTED LIVING - BEL AIR I		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 SAINT FRANCIS ROAD BEL AIR, MD 21015		
(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 6/18/2012 and 6/26/12, an unannounced visit was conducted for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Program Regulations, as they relate to providing services for all residents related to a bed increase. The visit included a tour of the facility, interview with the Assisted Living Manager, and review of the administrative records.</p> <p>The facility was determined to be in compliance with COMAR 10.07.14, Assisted Living Program Regulations, as it relates to providing services for an increase of residents from sixteen(16) to seventeen(17).</p>	E 000		

OHCQ

TITLE

(X6) DATE

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