Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	AM000544		08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN ASSISTED LIVING - BEL AIR I	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	Initial Comments On 8/9/2012 and 8/13/12, 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. 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 seventeen(17) to eighteen(18).	E 000		

OHCQ

TITLE (X6) DATE

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