

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/08/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CEDAR GROVE ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>110 NICOLETTE ROAD PARKERSBURG, WV 26104</b>
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(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 Comment</p> <p>Investigation of Complaint #40143 Start Date: 10/07/25 End Date: 10/08/25 The complaint was unsubstantiated, and no deficiencies were cited.</p>	E 000		

Office of Health Facility Licensure and Certification LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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