

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 03/28/2007
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NAME OF PROVIDER OR SUPPLIER ELMHURST, THE HOUSE OF FRIENDSHIP, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1228 NATIONAL ROAD Wheeling, WV 26003
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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 003	Annual Licensure Survey March 28, 2007 Census: 37 Jane Cost, RN HFNS II Louise Hall, RN HFNS II	E 003		

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