

WV DHHR, Office of Health Facility Licensure and Certification

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 506030 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/07/2007 |
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| NAME OF PROVIDER OR SUPPLIER LOVE AND CARE ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 5368 DUPONT ROAD Parkersburg, WV 26102 |
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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 |
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| E 003 | <p>Annual Licensure Survey</p> <p>August 6-7, 2007 Census 21</p> <p>Surveyors: Kathy Beauchamp, HFNS II Betty Marine, LSW, HFS II</p> <p>No deficiencies Technical assistance given</p> | E 003 | | |

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