

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>506124</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/16/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLANDS RETIREMENT COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE BRADLEY FOSTER DR HUNTINGTON, WV 25701</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 004	<p>Complaint Investigation</p> <p>Date: May 15-16, 2019</p> <p>Census: 71</p> <p>Complaint ID# WV00022456</p> <p>No Deficiencies Cited</p>	E 004		

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