

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>507544</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/23/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KANAWHA PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH PARK ROAD Charleston, WV 25304</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: January 22-23, 2018 CENSUS: 54 COMPLAINT ID: WV00021712 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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