

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 507567	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2021
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NAME OF PROVIDER OR SUPPLIER ELISON INDEPENDENT & ASSISTED LIVING OF M	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 MAPLEWOOD DRIVE BRIDGEPORT, WV 26330
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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 001	<p>Initial Comments</p> <p>Infection Control Survey Facility Name: Elmcroft of Maplewood Event ID: 0G9811 Start/End Date: 01/06/21 1:45 p.m. 01/06/21 4:00 p.m. Census: 31 No deficiencies cited. Ombudsman notified via e-mail.</p>	E 001		

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