| Statement of Deficiencies | (X1) Provider/Supplier/CLIA Identification Number<br><br>51D0661823 | (X3) Date Survey Completed<br><br>02/12/2018 |
|---|---|---|
| **Name of Provider or Supplier**<br><br>Grafton City Hospital | **Street Address, City, State**<br><br>1 Hospital Plaza, Grafton, WV | |
| For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency. | | |

| (X4) ID Prefix Tag | Summary Statement of Deficiencies |
|---|---|
| **No Tags** | No deficiency details available. |