STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETED MAME OF PROVIDER OR SUPPLIER 495388 B. WING TELET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TSTI HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155 TSTI HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155 TSTI HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155 COM	DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D.							X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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