

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/12/2023
NAME OF PROVIDER OR SUPPLIER GAINESVILLE HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155		
(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
{F 000}	Initial Comments An offsite paper revisit survey was conducted on 4/12/2023 for all previous deficiencies cited on 3/1/2023. All deficiencies have been corrected. The facility is in compliance with all regulations surveyed.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE