COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
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Date

Facility Contact
Facility Name
Address
Address

Statement of Deficiencies

During a recent visit to your facility on (Date), a Level of Care Review was completed for (Individual's name). The following deficiencies were identified during the review.

Section	Deficiency	Regulation/Guidance	CAP Due Date

Your timely response is greatly appreciated. If there are any questions or concerns regarding these findings, please feel free to contact me at (Email or telephone number).

Respectfully Submitted,

Name
Family Resource Consultant/Manager
Division of Developmental Services