STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495383	A. BUILDING **01, 02, 03** B. WING _____	**04/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS N SANDERS NURSING HOME, INC	**7385 WALKER AVE** **GLOUCESTER, VA 23061**

(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) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: one story brick building Sprinkler status: fully sprinklered An unannounced recertification Life Safety Code survey was conducted on 22 Apr 2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 edition of NFPA-101, Life Safety Code (Exisiting) regulations. The facility was in compliance with the requirements for participation Medicare and Medicaid.	K 000		
K 000	INITIAL COMMENTS Description of structure: one story brick building Sprinkler status: fully sprinklered An unannounced construction Life Safety Code survey was conducted on 22 Apr 2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 edition of NFPA-101, Life Safety Code (New) regulations. The facility was in compliance with the requirements for participation Medicare and Medicaid. Description of structure: one story brick building Sprinkler status: fully sprinklered An unannounced construction Life Safety Code survey was conducted on 22 Apr 2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 edition of NFPA-101, Life Safety Code (New) regulations. The facility was in compliance with the requirements for	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 participation Medicare and Medicaid.	K 000		