

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - RIVERSIDE SANDERS RETIREMNT COMMUNITY MAIN BLDG</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/16/2018</b>
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NAME OF PROVIDER OR SUPPLIER <b>FRANCIS N SANDERS NURSING HOME, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7385 WALKER AVE GLOUCESTER, VA 23061</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>Description of structure: 1 Story V (111) Building Sprinkler status: Fully Sprinklered</p> <p>An unannounced Life Safety Code Initial Survey conducted on 05/16/18 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Health Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.</p>	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.

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NAME OF PROVIDER OR SUPPLIER <b>FRANCIS N SANDERS NURSING HOME, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7385 WALKER AVE GLOUCESTER, VA 23061</b>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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