PRINTED: 04/18/2022 FORM APPROVED

State of Virginia

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED	STATEMENT OF DEFICIENCIES			(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7385 WALKER AVE GLOUCESTER, VA 23061  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  O4/18/2022  DEFICIENCE  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETE DATE DEFICIENCY)	AND PLAN OF CORRECTION		F CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7385 WALKER AVE GLOUCESTER, VA 23061   (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  (BUT COMPLETE DATE  COMPLETE DATE  COMPLETE DATE  DEFICIENCY)			VA0384	B. WING			22	
FRANCIS N SANDERS NURSING HOME, INC  GLOUCESTER, VA 23061  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  GLOUCESTER, VA 23061  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)  (X5) COMPLETE DATE	I FRANCIS N SANDERS NURSING HOME. INC							
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	GLOUCESTER, VA 23061							
{F 000} Initial Comments {F 000}	PREFIX	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY.	MPLETE		
	{F 000} Initial (	I Comments	Initial Comments	{F 000}				
An offsite paper revisit survey was conducted on 04/18/2022 for all previous deficiencies cited on 03/03/2022. All deficiencies have been corrected. The facility is in compliance with all regulations surveyed.	An offs 04/18/ 03/03/ correc	ffsite paper revis 8/2022 for all pre 3/2022. All defic ected. The facilit	An offsite paper revisit survey was conducted on 04/18/2022 for all previous deficiencies cited on 03/03/2022. All deficiencies have been corrected. The facility is in compliance with all					

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

TITLE (X6) DATE