### Name of Provider or Supplier

**FRANKLIN OAKS NURSING AND REHABILITATION CENTER**

- **Street Address, City, State, Zip Code:**
  1704 NC HWY 39 N
  LOUISBURG, NC  27549

### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CLIA Identification Number:
- 34535

#### (X2) Multiple Construction

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<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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No deficiencies were cited as a result of the complaint investigation survey on 3/13/19. Event ID #ZBIG11. CI NC00149195, NC00147229 and NC00149009.

### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

### Date Survey Completed
- C 03/13/2019

### Date
- 03/25/2019 Electronically Signed

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.