A. BUILDING ________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345335

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 08/06/2020

NAME OF PROVIDER OR SUPPLIER
FRANKLIN OAKS NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1704 NC HIGHWAY 39 N
LOUISBURG, NC  27549

(X4) ID PREFIX TAG

(X5) ID PREFIX TAG

(PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

ID PREFIX TAG

COMPLETION DATE

08/07/2020

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE
Electronically Signed

TITLE

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.