**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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

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<tr>
<th>(F 000)</th>
<th>INITIAL COMMENTS</th>
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<tr>
<td>An on-site follow up was conducted 04/26/2021. The facility is in compliance effective 03/19/2021.</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

*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.