AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED R 345335 B. WING O5/23/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN OAKS NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (COMP								APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED A. BUILDING 345335 B. WING 05/23/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05/23/202 FRANKLIN OAKS NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1704 NC HIGHWAY 39 N (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE 00 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE 0D Yadd REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS {F 000} INITIAL COMMENTS {F 000} INITIAL COMMENTS {F 000} INITIAL COMMENTS INITIAL compliance effective Image: Complinance	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
345335 B. WING O5/23/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1704 NC HIGHWAY 39 N FRANKLIN OAKS NURSING AND REHABILITATION CENTER 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549 (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) (COMP DA {F 000} INITIAL COMMENTS {F 000} {F 000}					-				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN OAKS NURSING AND REHABILITATION CENTER 1704 NC HIGHWAY 39 N (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS {F 000} A paper follow-up was conducted on 05/23/24 and the facility is back into compliance effective (F 000)	345335		B. WING	B. WING					
FRANKLIN OAKS NURSING AND REHABILITATION CENTER LOUISBURG, NC 27549 (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) (2) (COMP DEFICIENCY {F 000} INITIAL COMMENTS {F 000} {F 000} {F 000} (F 000)	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
Image: Comparison of the provided of the provid	FRANKLIN OAKS NURSING AND REHABILITATION CENTER				17	04 NC HIGHWAY 39 N			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP DU DEFICIENCY) {F 000} INITIAL COMMENTS {F 000} A paper follow-up was conducted on 05/23/24 and the facility is back into compliance effective {F 000}					LOUISBURG, NC 27549				
A paper follow-up was conducted on 05/23/24 and the facility is back into compliance effective	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/	ULD BE COMPLETION		
and the facility is back into compliance effective	{F 000}	INITIAL COMMENTS		{F (000}				
		and the facility is bacl							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DAT	ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE	

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.

PRINTED: 05/23/2024