## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  FRANKLIN GROUP HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  W 000 INITIAL COMMENTS  A revisit was conducted on 6/23/22 for all previous deficiencies cited on 4/5/22. All deficiencies were corrected and no new non-compliance was found. The facility is in compliance with all regulations surveyed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  FRANKLIN GROUP HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  1101 FRANKLIN BLVD  GASTONIA, NC 28054   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  A revisit was conducted on 6/23/22 for all previous deficiencies cited on 4/5/22. All deficiencies were corrected and no new non-compliance was found. The facility is in			34G141	B. WING			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000 INITIAL COMMENTS  A revisit was conducted on 6/23/22 for all previous deficiencies cited on 4/5/22. All deficiencies were corrected and no new non-compliance was found. The facility is in			i -		1101 FRANKLIN BLVD	<b>I</b>	00/23/2022
A revisit was conducted on 6/23/22 for all previous deficiencies cited on 4/5/22. All deficiencies were corrected and no new non-compliance was found. The facility is in	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRI		COMPLETION
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		A revisit was conduct previous deficiencies deficiencies were con non-compliance was compliance with all research	ted on 6/23/22 for all cited on 4/5/22. All rected and no new found. The facility is in egulations surveyed.				

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

(X6) DATE

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.