

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

PRINTED: 12/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER FRANK STREET ICF/MR			STREET ADDRESS, CITY, STATE, ZIP CODE 719 FRANK STREET ROXBORO, NC 27573		
(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)	(X5) COMPLETION DATE	
W 216	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v)</p> <p>The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1 of 1 newly admitted clients (#1) initial physical examination was done within 30 days of admission. The finding is:</p> <p>Review on 12/15/25 of client #1's record revealed he was admitted to the facility on 4/11/25. Further review revealed client #1 did not have a initial physical examination.</p> <p>During an interview on 12/16/25, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 did not have his initial physical examination.</p>	W 216			
W 340	<p>NURSING SERVICES CFR(s): 483.460(c)(5)(i)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in allowing clients to be independent during medication administration for 2 of 4 audit clients (#1 and #6). The findings are:</p> <p>During morning medication administration in the home on 12/16/25, Staff A did not inform clients #1 and #6 of their medications and the reason why they were taking them.</p>	W 340			

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

TITLE

(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.

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W 340	Continued From page 1 During an interview on 12/16/25, Staff A revealed they should have explained to clients #1 and #6 the medications they were taking and the reason why they are taking them. During an interview on 12/16/25, the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be telling clients #1 and #6 what medications they are taking and the reason why.	W 340			