

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

PRINTED: 03/04/2026
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 R 03/04/2026
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 000	INITIAL COMMENTS	W 000			
{W 216}	<p>A revisit was conducted on 3/4/26 for all previous deficiencies cited on 12/16/25. All deficiencies were not corrected and no new non-compliance was found. The facility is not in compliance with all regulations surveyed.</p> <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> <p>A follow up visit was conducted on 3/4/26.</p> <p>Review on 3/4/26 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 3/4/26, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 did not have his initial physical examination.</p>	{W 216}			

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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