# Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinical Laboratory Identification Number:** 345332

**Multiple Construction**

- **Building:**
- **Wing:**

**Date Survey Completed:** 06/22/2011

## Name of Provider or Supplier

**Brian Center Health and Rehab**

**Street Address, City, State, Zip Code:**

- **2501 Downing Street SW**
- **Wilson, NC 27895**

## Summary Statement of Deficiencies

- **ID Prefix Tag:** F 000

**Initial Comments:**

No deficiencies cited as a result of the complaint survey, conducted on 06/22/11, Event ID# HSHF11

**ID Prefix Tag:** F 000

**Provider's Plan of Correction**

- **Cross-Referenced to the Appropriate Deficiency:**

**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

**Date**

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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.