### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345080

**Multiple Construction: B. Wing _____________________________**

**Date Survey Completed:** 03/01/2012

**Name of Provider or Supplier:** BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT

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

- 220 13TH AVE PLACE NW
- HICKORY, NC 28601

**Overview:** No deficiencies cited as result of survey event ID# 0QCP11.

#### Initial Comments

- **F 000**

  No deficiencies cited as result of survey event ID# 0QCP11.

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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.**

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

**Title**

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**Date**

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**Event ID:** 0QCP11

**Facility ID:** 923004

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**Form CMS-2567(02-99) Previous Versions Obsolete**

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