### Statement of Deficiencies and Plan of Correction

**A. Building Provider/Supplier/CLIA Identification Number:**

- **B. Wing:**

**Date Survey Completed:**

- **C:** 04/03/2012

**Name of Provider or Supplier:**

- **BRIAN CTR HEALTH & REHAB/GASTO**

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

- **969 COX RD GASTONIA, NC  28054**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No deficiencies were cited as a result of the complaint investigation Event ID# K47011.

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:**

**Date:**

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**Event ID:** K47011

**Facility ID:** 923002

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