STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _______________________________________________________
B. WING __________________________________________________________

(X3) DATE SURVEY COMPLETED
C 11/12/2015

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & REHAB/HE

STREET ADDRESS, CITY, STATE, ZIP CODE
1300 DON JUAN ROAD
HERTFORD, NC  27944

(X4) ID PREFIX TAG

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint survey. Event ID# 3BOT11. Complaint intake # NC00111843.

(X5) COMPLETION DATE

F 000

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE
Electronically Signed
11/16/2015

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.