### Statement of Deficiencies and Plan of Correction

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

- A. Building ____________________________
- B. Wing _____________________________

**Date Survey Completed:**

- C 04/18/2017

**Name of Provider or Supplier:**

- BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO

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

- 1700 WAYNE MEMORIAL DRIVE
- GOLDSBORO, NC  27534

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>There were no deficiencies cited as a result of the complaint investigation on 4/18/17 (Event 2KCC11)</td>
</tr>
</tbody>
</table>

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

- Electronically Signed 04/21/2017

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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.