**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**NAME OF PROVIDER OR SUPPLIER**

**BRIAN CENTER HLTH & RETIREMENT**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**204 DAIRY ROAD**

**CLAYTON, NC 27520**

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**ID** | **PREFIX** | **TAG** | **TOTAL**
---|---|---|---
**F 000** | INITIAL COMMENTS | | |

No deficiencies were cited as a result of the complaint investigation of 12/12/17. Event ID NITM11. Intake NC00133965.

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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed

12/28/2017

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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.