A. BUILDING ____________________________

(X1) PROVIDER/SUPPLIER/CLIA 
IDENTIFICATION NUMBER: 345317

B. WING ____________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED
06/14/2018

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HLTH & RETIREMENT

STREET ADDRESS, CITY, STATE, ZIP CODE
204 DAIRY ROAD
CLAYTON, NC  27520

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL 
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE 
CROSS-REFERENCED TO THE APPROPRIATE 
DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the 
complaint investigation: NC00136338, 
NC00139283, NC00137616, NC00139441, 
NC00137214, Event ID 1I8011 of 6/14/2018.

The facility is in compliance with the requirements 
of 42 CFR Part 483, Subpart B for Long Term 
Care Facilities (General Health Survey).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

F 000

Electronically Signed

07/02/2018

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.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 1I8011
Facility ID: 922982
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