**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ____________________________**

**IDENTIFICATION NUMBER:** 345265

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING ____________________________**

**DATE SURVEY COMPLETED:**

- **R-C**
- 09/25/2018

**NAME OF PROVIDER OR SUPPLIER**

- **BRIAN CENTER HEALTH & REHAB/YA**

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

- **1086 MAIN STREET NORTH**
- **YANCEYVILLE, NC 27379**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

**345265**

**09/25/2018**

**R-C**

**Printed:** 09/26/2018

**Form Approved:**

**Event ID:** 5KOA12

**Facility ID:** 923000

**If Continuation Sheet Page:** 1 of 1

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>F 000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The in-house follow-up was completed and the facility is back in compliance effective 9/11/2018.

Electronically Signed

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

**TITLE**

**DATE**

---

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.