**A. BUILDING ________________________**

**BRIAN CENTER HEALTH AND REHAB**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2501 DOWNING STREET SW
WILSON, NC  27895

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

**NAME OF PROVIDER OR SUPPLIER**

**DATE SURVEY COMPLETED**
10/15/2020

**ID PREFIX TAG**
**PREFIX**
**TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

**ID PREFIX TAG**
**PREFIX**
**TAG**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>An unannounced COVID-19 Focused Survey was conducted on 10/14/20 through 10/15/20. The facility was in compliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart-B-Requirements for Long Term Care Facilities. Event ID EEF111.</td>
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</tbody>
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| F 000 | INITIAL COMMENTS | F 000 | An unannounced COVID-19 Focused Infection Control Survey was conducted on 10/14/20 through 10/15/20. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. | |

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.

Electronically Signed

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