

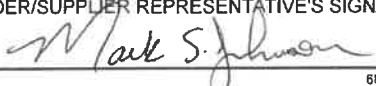
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRITTANY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WALKER STONE DRIVE CARY, NC 27513
---	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite re-licensure survey was conducted on 10/14/25 through 10/15/25. The facility is in compliance with the requirements of 10A NCAC 13D, the Rules for the Licensing of Nursing Homes. No deficiencies were cited on this re-licensure survey. Event ID#UJ4M11</p>	L 000		
-------	--	-------	--	--

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/27/2025
---	------------------------	-------------------------