CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.   STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPLIA C	ETED
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLIAN     A. BUILDING   B. WING   C     345337   B. WING   02/0     NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   215 COLLEGE STREET     PEAK RESOURCES - ALAMANCE, INC   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION     V(X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE   COMPLIAND (EACH CORRECTIVE ACTION SHOULD BE     PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   ID   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE     F 000   INITIAL COMMENTS   F 000   F 000   F 000   F 000   F 000	LETED )7/2017 (X5) COMPLETION
Image: Name of provider or supplier Street address, city, state, zip code   PEAK RESOURCES - ALAMANCE, INC Street address, city, state, zip code   (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) ID PREFIX TAG   F 000 INITIAL COMMENTS F 000 F 000	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE     PEAK RESOURCES - ALAMANCE, INC   215 COLLEGE STREET     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES     PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL     TAG   ID     P 000   INITIAL COMMENTS     F 000   INITIAL COMMENTS     There was no deficiency cited as result of CI,	(X5) COMPLETION
215 COLLEGE STREET GRAHAM, NC 27253     (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)   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000   F 000 <td< th=""><th>COMPLETION</th></td<>	COMPLETION
ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   ID   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000     There was no deficiency cited as result of CI,   F 000	COMPLETION
PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000     There was no deficiency cited as result of CI,   F 000	COMPLETION
There was no deficiency cited as result of CI,	
	(X6) DATE 02/13/2017

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.

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