STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING 02 - NEW REHAB ADDITION

B. WING _____________________________

STATEMENT OF DEFICIENCIES

(DATES SURVEY COMPLETED)

PRINTED: 04/21/2017

FORM APPROVED:

O.M.B. NO.: 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER

PEAK RESOURCES - PINELAKE

STREET ADDRESS, CITY, STATE, ZIP CODE

801 PINEHURST AVENUE
CARTHAGE, NC 28327

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration.

At time of survey:  
Total Certified Bed Count = 110  
Census = 79

No deficiencies were determined during the survey:

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

Title

(FUNEF) DATE  

Electronically Signed  

09/14/2016

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.