No deficiencies cited as result of survey event ID# BIJZ11.
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CILIA IDENTIFICATION NUMBER:

A. BUILDING: _____________________________

B. WING _____________________________

NH0403

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

C

10/20/2016

NAME OF PROVIDER OR SUPPLIER

PEAK RESOURCES-CHERRYVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE

7615 DALLAS CHERRYVILLE HIGHWAY

CHERRYVILLE, NC  28021

(X4) ID PREFIX TAG

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION

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

(X5) COMPLETE DATE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | D 000 | Initial Comments |
|---------------|--------------------------------------------------------------------------------------------------------------------------|------|-----------------
|               | No deficiencies cited as result of survey event ID# BL5X11.                                                              | D 000|                  |

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

BLSX11

If continuation sheet 1 of 1