**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING _____________________________**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345226

**B. WING _____________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED**

09/26/2017

**NAME OF PROVIDER OR SUPPLIER**

PEAK RESOURCES-OUTER BANKS

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

430 WEST HEALTH CENTER DRIVE

NAGS HEAD, NC  27959

**SUMMARY STATEMENT OF DEFICIENCIES**

*(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)*

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<th>F 000</th>
<th>INITIAL COMMENTS</th>
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<td>No deficiencies were cited as a result of this complaint investigation.</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed

10/12/2017

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.