**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345502

**NAME OF PROVIDER OR SUPPLIER**

**LAKE PARK NURSING AND REHABILITATION CENTER**

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

**3315 FAITH CHURCH ROAD**

**INDIAN TRAIL, NC 28079**

**DATE SURVEY COMPLETED**

**10/07/2014**

**FORM APPROVED**

**10/07/2014**

**PROVIDER'S PLAN OF CORRECTION**

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

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No deficiencies were cited as a result of the complaint investigation. Event ID# H0SF11.

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.

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

**DATE**

10/21/2014

Electronically Signed