A. BUILDING ________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345502

(B) WING _____________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

C 07/24/2020

NAME OF PROVIDER SUPPLIER

LAKE PARK NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3315 FAITH CHURCH ROAD

INDIAN TRAIL, NC 28079

(NAME OF PROVIDER OR SUPPLIER)

PROVIDER'S PLAN OF CORRECTION

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

(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)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced onsite complaint investigation was conducted 7/22/20 through 7/24/20. There was one (1) allegation which was unsubstantiated. Event ID# M2NJ11.

F 000

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

07/31/2020

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.