**Statement of Deficiencies and Plan of Correction**

A. Building ____________________________

B. Wing ____________________________

**Provider/Supplier/CLIA Identification Number:** 345502

**State of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**OMB No.: 0938-0391**

**Printed:** 10/04/2021

**Date Survey Completed:** 09/08/2021

**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

**Event ID:** V10N11

**Facility ID:** 970828

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<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>A unannounced complaint investigation survey was conducted on 9/8/2021. Event ID#V10N11. 3 of the 3 complaint allegations were not substantiated.</td>
<td></td>
<td></td>
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</tbody>
</table>

**Laboratory Director's or Provider/Supplier Representative's Signature:** Electronically Signed

**Title:**

**Date:** 10/01/2021

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.