

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
E0000	Initial Comments An unannounced recertification survey and complaint investigation were conducted from 03/16/26 through 03/19/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F36A1-H1.	E0000		
F0000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 03/16/26 through 03/19/26. Event ID #1F36A1-H1. The following intake was investigated 846069. 1 of the 1 complaint allegation did not result in deficiency.	F0000		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F0577		

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 reverse for further 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	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0577 SS = C	<p>Continued from page 1</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, and resident and staff interviews, the facility failed to post survey results in the lobby in a location easily accessible to all residents and visitors without asking and failed to post signage as to the location of the survey results for 2 of 4 days of the survey (3/18/26 and 3/19/26).</p> <p>The findings included:</p> <p>A Resident Council meeting was conducted on 3/18/2026 at 9:45AM. There were 8 residents that regularly attended Resident Council meetings that were present (Resident #2, Resident #6, Resident #8 Resident #78, Resident #85, Resident #91, Resident #94, and Resident #96). The Resident Council participants indicated they did not know the location of the survey results. Resident #94 revealed that in the past the facility posted a sign that stated they passed the survey.</p> <p>An observation was made on 3/18/2026 at 11:50 AM at the receptionist desk in the main lobby and adjacent sitting area revealed no survey results were accessible nor was signage visible that directed residents and visitors where the survey results were located.</p> <p>An observation at the receptionist desk and interview with the Receptionist were conducted on 3/19/2026 at 12:54 PM. There was no visible signage which directed visitors or residents to the location of the survey results. The Receptionist was asked where the survey results were located. The Receptionist indicated that visitors and residents just needed to ask for the survey book and she pointed to a white binder on the reception desk (countertop) leaning against the wall which was perpendicular to the desk on the left side if you were facing the reception desk/ counter. The countertop was approximately 4 feet from the floor, and the binder was behind foliage and decorations. There was no identification visible on the binder cover. The white binder was turned over by the Receptionist and had the following information on the cover of the binder, "The Well Being Of Our Residents is very important to us. Please Refer To Notebook In Each Neighborhood For Information Regarding: Bill Of Rights</p>	F0577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0577 SS = C	Continued from page 2 for Nursing Home Residents; Notice of Privacy Practices; Resident and Advocacy Groups, Grievance Policy Information, Nondiscrimination Policies; Results of Compliance Survey". The observation of the binder revealed the location of the binder was within reach of ambulatory residents and visitors. In an interview on 3/19/2026 at 1:51 PM, the Administrator stated the survey results were in the lobby at the receptionist desk and each neighborhood had a copy of the results. She stated the signage of where the results were located was printed on the front of the survey binder. She stated that the residents were told the survey results of each survey during the resident council meeting.	F0577		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0636 SS = D	<p>Continued from page 3</p> <p>(x) Disease diagnosis and health conditions.</p> <p>(xi) Dental and nutritional status.</p> <p>(xii) Skin Conditions.</p> <p>(xiii) Activity pursuit.</p> <p>(xiv) Medications.</p> <p>(xv) Special treatments and procedures.</p> <p>(xvi) Discharge planning.</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to complete annual Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 2 of 24 residents reviewed for MDS assessments (Residents #75 and #102).</p> <p>The findings included:</p>	F0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0636 SS = D	<p>Continued from page 4</p> <p>a. Resident #75 was admitted to the facility on 1/29/24.</p> <p>Resident #75's annual MDS assessment with an ARD of 2/6/26 indicated it was "in progress" and was not completed.</p> <p>b. Resident #102 was admitted to the facility on 1/22/25.</p> <p>Resident #102's annual MDS assessment with an ARD of 1/28/26 indicated it was "in progress" and was not completed.</p> <p>An interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 3/19/26 at 11:02 a.m. MDS Coordinator #1 and MDS Coordinator #2 revealed they both were responsible for transmitting MDS assessments. Upon review of Resident #75 and Resident #102's MDS assessments, MDS Coordinator #1 stated the assessments were incomplete due to transitioning from previous job duties.</p> <p>On 3/19/26 at 11:22 a.m. an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated she was aware some MDS assessments were behind and she expected they be completed timely to meet federal regulations. The Administrator stated she was aware some MDS assessments were past due and her expectation was that MDS assessments should be completed timely.</p>	F0636		
F0638 SS = E	<p>Qrtly Assessment at Least Every 3 Months</p> <p>CFR(s): 483.20(c)</p> <p>§483.20(c) Quarterly Review Assessment</p> <p>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interview the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 10 of 24 residents reviewed for MDS assessments (Residents #3, #9, #37, #50, #99, #49, #16, #57, #77 and #83).</p> <p>The findings included:</p> <p>a. Resident #3 was admitted to the facility on 3/28/24.</p>	F0638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0638 SS = E	<p>Continued from page 5</p> <p>Resident #3's quarterly MDS assessment with an ARD of 2/4/26 indicated it was "in progress" and was not completed.</p> <p>b. Resident #9 was admitted to the facility on 1/21/19.</p> <p>Review of Resident #9's quarterly MDS assessment with an ARD of 1/24/26 indicated it was "in progress" and was not completed.</p> <p>c. Resident #37 was admitted to the facility on 1/28/25.</p> <p>Resident #37's quarterly MDS assessment with an ARD of 2/6/26 indicated it was "in progress" and was not completed.</p> <p>d. Resident #50 was admitted to the facility on 2/25/21.</p> <p>Resident #50's quarterly MDS assessment with an ARD of 1/24/26 indicated it was "in progress" and was not completed.</p> <p>e. Resident #99 was admitted to the facility on 1/20/25.</p> <p>Resident #99's quarterly MDS assessment with an ARD of 2/23/26 indicated it was "in progress" and was not completed.</p> <p>f. Resident #49 was admitted to the facility on 8/7/24.</p> <p>Resident #49's quarterly MDS assessment with an ARD of 1/16/26 indicated it was "in progress" and was not completed.</p> <p>g. Resident #16 was admitted to the facility on 4/17/25.</p> <p>Resident #16's quarterly MDS assessment with an ARD of 1/24/26 indicated it was "in progress" and was not completed.</p> <p>h. Resident #57 was admitted to the facility on 10/31/25.</p> <p>Resident #57's quarterly MDS assessment with an ARD of 2/6/26 indicated it was "in progress" and was not completed.</p> <p>i. Resident #77 was admitted to the facility on 7/8/25.</p>	F0638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Community			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 Wade Coble Drive , Burlington, North Carolina, 27215	
(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
F0638 SS = E	<p>Continued from page 6 Resident #77's quarterly MDS assessment with an ARD of 1/28/26 indicated it was "in progress" and was not completed.</p> <p>j. Resident #83 was admitted to the facility on 10/30/25.</p> <p>Resident #83's quarterly MDS assessment with an ARD of 1/30/26 indicated it was "in progress" and was not completed.</p> <p>An interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 3/19/26 at 11:02 a.m. MDS Coordinator #1 and MDS Coordinator #2 revealed they both were responsible for transmitting MDS assessments. Upon review of Residents #3, #9, #37, #50, #99, #49, #16, #57, #77 and #83's MDS assessments, MDS Coordinator #1 stated the assessments were incomplete due to transitioning from previous job duties.</p> <p>On 3/19/26 at 11:22 a.m. an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated she was aware some MDS assessments were behind and she expected they be completed timely to meet federal regulations. The Administrator stated she was aware some MDS assessments were past due and her expectation was that MDS assessments should be completed timely.</p>	F0638		