STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345235	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Lakes Community	3802 Wade Coble Drive Burlington, NC 27215

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007 Based on observations, record review, and staff and Responsible Party (RP) interviews, the facility failed to protect a resident's right to be free from physical restraint when Nurse Aide (NA) #1 held Resident #1 hands in front of his chest during incontinent care when Resident #1 started swinging his arms and hitting the nurse aide. This was for 1 of 1 resident reviewed for physical restraint (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE]. His diagnoses included vascular dementia with behavioral disturbances. The admission Minimum Data Assessment (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment. The MDS documented he had physical behaviors directed toward others 1 to 3 days. Review of Resident #1's care plan dated 2/5/25 showed a behavior care plan related to dementia with behavioral disturbance. Behaviors demonstrated included: agitation, yelling and combative with care. Interventions included, explaining care before starting, provide as needed medications as ordered, and stopping to allow time for resident to calm down before proceeding with care. A review of Resident #1's physician orders showed an order dated 2/6/25 for lorazepam (anti-anxiety medication) 1 mg tablet every 6 hours as needed for an anxiety. A review of Resident #1's February medication administration record showed his most recent dose of lorazepam 1mg was received on 2/16/25 at 8:17 am. A review of the Initial Allegation Report completed on 2/27/25 at 11:15 am regarding an allegation of staff to resident abuse involving Resident #1 stated the facility had been made aware that a NA #1 was observed holding Resident #1's hands then hit him on the chest. Resident #1 was assessed by a nurse and the facility doctor and did not have any visible marks or injury. Resident #1 was exhibiting no mental distress. The accused employee was suspended pending investigation. The facility reported the allegation of abuse to the police and adult protective services on 2/27/25. There was 1 witness to the alleged abuse incident. (continued on next page)

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	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility investigation of the incident was completed and submitted to the state agency on 3/4/25. Through their investigation the facility concluded the abuse allegation was unsubstantiated. A typed interview dated 2/27/25 for NA #1 read in part, NA #1 stated while attempting to assist with incontinent care for Resident #1, he became combative He was hitting and I was holding his hands down. I did not hit him, I just held his hands so he wouldn't be able to hit my face. During an interview with NA #1 on 3/10/25 at 12:37 pm, she stated she was asked to assist NA #2 with incontinent care for Resident #1 on 2/26/25; she was unsure of the time but felt like it was close to the end of her shift. NA #1 stated, while NA #2 went to get a clean incontinent brief for Resident #1, she waited with him while he was on his side telling him she and NA #2 were going to clean him up. NA #1 stated Resident #1 reached out and hit her in the face so she held both of his hands. NA #1 reported she didn't hold his hands tight because Resident #1 was able to pull one hand free and hit her again on the arm. NA #1 stated she told Resident #1, No, we do not hit. NA #1 stated when NA #2 came back into the room, NA #2 told her she couldn't hold Resident #1's hands. NA #1 then stated she told NA #2 that Resident #1 would keep trying to hit her if she didn't. NA #1 stated she held both of Resident #1's hands and rested them on his chest. NA #1 reported she did not hit Resident #1 at any time. NA #1 stated both she and NA #2 finished providing care and both exited the room. NA #1 reported she was in the room for less than 10 minutes total and it took approximately 5 minutes to clean him up and replace his brief. NA #1 stated she wasn't holding Resident #1's hands the entire time; only when he became combative with her. NA #1 stated she didn't feel like she was restraining him because she was rubbing his hands while holding them and talking to Resident #1 trying to divert his attention while NA #2 cleaned him up. A typed interview dated 2/27/25 for NA #2 read in part, NA #1 and NA #2 were in Resident #1's room providing care. NA #2 reported when she returned to the room with a clean [brief], she saw NA #1 holding Resident #1's hands. NA #2 stated Resident #1 became combative and began hitting NA #1. NA #2 reported that Resident #1 pulled his hand free and it looked like NA #1 hit Resident #1 on the chest. NA #2 stated she told NA #1 she couldn't do that and NA #1 told her that if she didn't hold his hands, Resident #1 would hit her. NA #2 reported they finished providing care and then left the room. Multiple attempts to contact NA#2 for interview were unsuccessful. A typed interview dated 2/27/25 for Nurse #1 read in part, Nurse #1 called the DON on 2/27/25 to let her know that NA #2 told her that NA #1 was holding Resident #1's hands and had hit him during incontinent care. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #1 on 3/10/25 at 2:02 pm she stated she worked 3rd shift (11:00 pm-7:00 am), was very familiar with Resident #1 and had worked with him many times since admission. Nurse #1 reported that Resident #1 could be combative during care at times. Nurse #1 stated NA #2 told her at the end of her shift on 2/27/25 (7:00 am), that she was concerned about the way NA #1 treated Resident #1 during incontinent care on 2/26/25. Nurse #1 stated NA #2 told her NA #1 held Resident #1's hands to prevent him from hitting her during incontinent care and that she felt like NA#1 hit him in the chest while doing so. Nurse #1 stated she had worked with NA #1 several times and had never witnessed any issues. Nurse #1 reported that NA #2 told her she had not told her about the incident because she wasn't sure what to say. Nurse #1 also reported that NA #2 told her she went home, thought about it, and thought it could have been seen as abusive and decided to say something during the next shift. Nurse #1 stated NA #2 told her she had seen that Nurse #1 was busy and other people were around so NA#2 chose not to speak to her about the incident until the end of the shift on 2/27/25 (7:00 am). Nurse #1 stated that she had a family emergency and left quickly at the end of her shift on 2/27/25 (7:00 am) without notifying the Director of Nursing (DON). Nurse #1 explained she called the DON later that morning on 2/27/25 (approximately 11:00 am) to notify her of the allegation made by NA #2. Nurse #1 added that NA #2 told her she knew NA #1 did not work again until the weekend and did not see the urgency in letting Nurse #1 know about her concerns. A phone interview was conducted with Resident #1's Responsible Party (RP) on 3/10/25 at 2:17 pm. The RP stated she had been made aware of the incident between NA #1 and Resident #1 on 2/27/25. The RP reported that she visited with Resident #1 on 2/27/25 and did not notice any new bruises or scratches that would lead her to believe Resident #1 had been abused. The RP reported she understood Resident #1 could be very challenging to care for and felt like the facility took excellent care of him. A review of a progress/assessment note dated 2/27/25 showed that the facility doctor had examined Resident #1. Documentation showed no new bruises or skin tears were noted during the examination. During an interview with the facility Doctor on 3/11/25 at 11:02 am, she stated she was present at the facility when the DON was made aware of the allegation. The doctor reported that she completed a head-to-toe assessment of Resident #1 and found nothing that would have made her feel like Resident #1 had been abused. She stated Resident #1 was in a good mood that morning and had a pleasant demeanor. The facility Doctor reported that Resident #1 can be difficult to deal with at times but she added NA #1 should have walked away, let Resident #1 calm down and then re-approached him without having to feel like she needed to hold his hands during care. The Doctor also stated that Resident #1 had an as needed anxiety medication ordered for those behaviors which she has now ordered scheduled. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 3/10/25 at 1:04 pm, she stated NA#1 had been working at the facility since the second week of January 2025. The DON reported that there had been no issues reported by staff members or residents concerning NA #1 prior to this allegation. The DON stated that Nurse #1 called her around 11:00 am on 2/27/25 to report the alleged incident. The DON reported she was told by Nurse #1, during 3rd shift care on 2/26/27, NA #2 allegedly observed NA #1 holding Resident #1's hands and hitting him in the chest. The DON stated she immediately completed the initial report and began investigating the incident. The DON reported that NA #1 had not worked since the alleged incident and advised her by phone that she was not to return until contacted by administration. The DON reported that, during an interview with NA #1, she stated she did not hit Resident #1 at any time and was just holding his hands to prevent Resident #1 from hitting her. The DON explained that after a thorough investigation, they were unable to determine what exactly happened between NA #1 and Resident #1 and were unable to confirm whether or not NA #1 hit Resident #1 or if she was holding his hands to his chest to avoid being hit herself. The DON stated although the facility had unsubstantiated the abuse allegation, NA #1 was dismissed from her position based on the fact that she admitted to holding Resident #1's hands during care to prevent him from being combative which goes against their policy for restraining residents. During an interview with the Administrator on 3/10/25 at 3:10 PM, the Administrator stated the DON had made her aware of the incident on 2/27/25 as soon as Nurse #1 reported it to her. The Administrator explained the DON had conducted a thorough investigation and reported the findings to her. She stated she had agreed based on what was described that it was unclear what exactly occurred between NA #1 and Resident #1. The Administrator stated the abuse allegation was not substantiated by the facility but was in agreement with dismissing NA #1 from her position based on the fact she admitted to holding Resident #1's hands during care. The Administrator stated NA #1 should have walked away to allow Resident #1 to calm down instead of holding his hands in an attempt to calm him down as NA #1 had stated. Review of the facility provided draft plan of correction showed it was missing information on new effective interventions to protect the resident from further abuse.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42007 Based on record review and staff interviews, the facility failed to follow and implement their abuse policy and procedures in the area of identification, protection for the resident and reporting for 1 of 1 resident reviewed for physical restraints (Resident #1). While Nurse Aide (NA) #1 was physically restraining Resident #1 during incontinent care, NA#2 did not intervene and did not report the incident immediately to licensed nursing or administrative staff. This failure would result in a lack of protection for other residents. Findings included: The facility policy titled; Abuse, Neglect, and Exploitation revised 1/11/24 indicated facility staff must immediately report allegations of abuse to facility leadership. The policy included the different types of abuse, including physical restraints and that it was the staff members responsibility to intervene immediately as well as notifying nursing leadership. A facility initial report dated 2/27/25 revealed the facility received an allegation of abuse on 2/27/25 from Nurse #1. Nurse #1 had stated she was told by NA#2 on 2/27/25 at 7:00 AM that NA#2 witnessed NA #1 holding Resident #1's hands during incontinence care and hitting Resident #1 in the chest. NA#2 reported that the incident occurred 2/26/25 (time not recalled). The Director of Nursing (DON) sent the initial incident report to the Department of Health and Human Services (DHHS) fax 2/27/25 at 11:15 AM. During an interview with Nurse #1 on 3/10/25 at 2:02 pm she stated she worked 3rd shift (11:00 pm-7:00 am). Nurse #1 stated NA #2 told her at the end of her shift on 2/27/25 (7:00 am), that she was concerned about the way NA #1 treated Resident #1 during incontinent care on 2/26/25. Nurse #1 stated NA #2 told her NA #1 held Resident #1's hands to prevent him from hitting her during incontinent care and that she felt like NA#1 hit him in the chest while doing so. Nurse #1 stated she had worked with NA #1 several times and had never witnessed any issues. Nurse #1 reported that NA #2 told her she had not told her about the incident because she wasn't sure what to say. Nurse #1 also reported that NA #2 told her she went home, thought about it, and thought it could have been seen as abusive and decided to say something during the next shift. Nurse #1 stated NA #2 told her she had seen that Nurse #1 was busy and other people were around so NA#2 chose not to speak to her about the incident until the end of the shift on 2/27/25 (7:00 am). Nurse #1 stated that she had a family emergency and left quickly at the end of her shift on 2/27/25 (7:00 am) without notifying the DON. Nurse #1 explained she called the DON later that morning on 2/27/25 (approximately 11:00 am) to notify her of the allegation made by NA #2. Nurse #1 added that NA #2 told her she knew NA #1 did not work again until the weekend and didn't feel there was an urgency in letting Nurse #1 know about her concerns. A typed interview dated 2/27/25 for NA #2 read in part, NA #1 and NA #2 were in Resident #1's room providing care. NA #2 reported when she returned to the room with a incontinent brief, she saw NA #1 holding Resident #1's hands. NA #2 stated Resident #1 became combative and began hitting NA #1. NA #2 reported that Resident #1 pulled his hand free and it looked like NA #1 hit Resident #1 on the chest. NA #2 stated she told NA #1 she couldn't do that and NA #1 told her that if she didn't hold his hands, Resident #1 would hit her. NA #2 reported they finished providing care and then left the room. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple attempts to interview NA #2 were unsuccessful. During an interview with the DON on 3/10/25 at 1:04 pm, she stated that Nurse #1 called her around 11:00 am on 2/27/25 to report the alleged incident. The DON reported she was told by Nurse #1, during 3rd shift care on 2/26/27, NA #2 allegedly observed NA #1 holding Resident #1's hands and hitting him in the chest. The DON stated she immediately completed the initial report and began investigating the incident. The DON reported that NA #1 had not worked since the alleged incident and advised her by phone that she was not to return until contacted by administration. The DON reported that she was unsure why NA #2 had delayed reporting her concerns other than NA #2 reported to her she was unsure of what she witnessed. The DON also explained that Nurse #2 left the facility immediately on 2/27/25 due to a family emergency so there was a delay informing her (DON) of the incident. The DON reported Nurse #1 called her to report what NA #2 told Nurse#1 later that morning on 2/27/25 at approximately 11:00 am. During an interview with the Administrator on 3/10/25 at 3:10 PM, the Administrator stated the DON had made her aware of the incident on 2/27/25 as soon as Nurse #1 reported it to her. The Administrator explained the DON had conducted a thorough investigation and reported the findings to her. The Administrator stated that NA #2 should have immediately reported her concerns to Nurse #1 and Nurse #1 should have immediately reported what she had learned to the DON and that did not occur. The Administrator stated the facility began a plan of correction regarding the abuse allegation and not immediately reporting the incident to facility leadership on 2/27/25. Review of the facility provided draft plan of correction showed it was missing information regarding the facility plans to effectively monitor its performance to make sure that solutions are sustained.