**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345545

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

R

10/10/2018

**NAME OF PROVIDER OR SUPPLIER**

TWIN LAKES COMMUNITY MEMORY CARE

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

3810 HERITAGE DRIVE
BURLINGTON, NC  27215

**ID**  **PREFIX**  **TAG**  **ID**  **PREFIX**  **TAG**  **SUMMARY STATEMENT OF DEFICIENCIES**  **ID**  **PREFIX**  **TAG**  **DATE**

F 000  INITIAL COMMENTS

A paper revisit was conducted on 10/10/18. The facility is in compliance as of 10/4/18

F 000

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

Electronically Signed

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.