STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 06/06/25.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff B) who administered medications had completed the state-approved 5-hour,10-hour, or 15-hour medication aide (MA) training courses and the Medication Administration Competency Validation Clinical Skills Checklist as required. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a Habilitation Technician on 04/01/25. -There was a job description signed on 04/04/25 with duties and responsibilities that included: administer medication ordered by physicians in accordance with applicable status regulations, policies, and procedures, maintain medication administration records, and conduct medication administration inventories.	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 131	Continued From page 1 -There was documentation Staff B completed the Medication Administration Competency Validation Clinical Skills Checklist on 04/02/25 signed by the Administrator/Owner. -There was documentation Staff B completed the state-approved 15-hour Medication Aide (MA) training courses signed by the Administrator/Owner on 04/02/25. -There was documentation Staff B completed Medication Administration Training provided by a Cardiopulmonary Training Center on 08/15/24 and signed by a Registered Nurse. -There was no documentation Staff B passed the MA written exam. -There was no MA employment verification form for Staff B. Review of residents' medication administration records (MAR) for April 2025 revealed Staff B administered medications to the residents 14 of 30 days. Review of residents' MARs for May 2025 revealed Staff B administered medications to the residents 5 of 31 days. Attempted telephone interview with Staff B on 06/06/25 at 5:39pm was unsuccessful. Interview with the Administrator/Owner on 06/06/25 at 4:20pm revealed: -She was a Registered Nurse (RN). -She completed the Medication Administration Competency Validation Clinical Skills Checklist found in Staff B's record and signed it. -She completed the state-approved 15-hour medication aide (MA) training courses certificate after she conducted her own training. -She was told she could use the state form as a certificate of completion for 15-hour medication	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 131	Continued From page 2 aide (MA) training courses that she provided. -She had not received state approval to conduct state training. -Staff A and Staff B had not taken the MA test. -She was told she could continue to re-do the Medication Administration Competency Validation Clinical Skills Checklist over until staff took the MA written exam and they could administer medication. -Staff A and Staff B were hired as Habilitation Technicians.	C 131		
C 134	10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge 10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge The supervisor-in-charge, who is responsible to the administrator for carrying out the program in a family care home in the absence of the administrator, shall meet the following requirements: (1) be 21 years or older, if employed on or after the effective date of this Rule; (2) the supervisor-in-charge, employed on or after August 1, 1991, shall be a high school graduate or certified under the GED Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and (3) earn 12 hours a year of continuing education credits related to the management of adult care homes and care of aged and disabled persons. Readopted Eff. July 1, 2021.	C 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 134	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews, the Administrator failed to ensure the supervisor-in-charge earned 12 hours of yearly continued education credits related to management of adult care homes and care of aged and disabled persons. The findings are: 1. Interview with Staff A on 06/06/25 at 7:35am and 8:25am revealed: -He introduced himself as a personal care aide (PCA) and overnight/live-in staff. -The Administrator/Owner was not present, but he would call her. -He worked alone for 2 weeks at a time, 24 hours per day, 7 days per week. -This was his first week back since May 2025. -He was a relief staff and worked as needed. -The census was 5 residents. -There were 4 residents present. -He administered medication to all residents at approximately 7:20am this morning. -He was not a medication aide (MA). Review of Staff A's personnel record on 06/06/25 revealed: -Staff A's hire date was 05/01/22 as a Habilitation Technician. -There was documentation of a General Education Diploma (GED). -There was no documentation of 12 hours of continued education credits related to management of adult care homes and care of aged and disabled persons. Second interview with Staff A on 06/06/25 at 4:20pm and 5:52pm revealed:	C 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 134	Continued From page 4 -His duties included cooking, cleaning, assisting residents with baths, administering medication to include insulin, and checking blood sugar levels. -He did not have any CEUs for the past 12 months. -If there was an issue, he called the Administrator to inform her and asked what she wanted him to do. -In the event of an emergency, he called 911 first. -He did not have an issue reaching the Administrator when he needed her. Interview with the Administrator/Owner on 06/06/25 at 4:20pm, 5:30pm and 6:15pm revealed: -Staff A was hired as a live in Habilitation Technician on 05/01/22. -Staff A just came back to work for her April 2025. -She did not know what a Supervisor-In-Charge was. -Whoever was working was in charge in her absence. -The staff were relief staff, not permanent staff. -She did not currently have permanent staff. -It was hard to find staff. -She thought Staff A met the requirements to manage the facility. -She lived 30 minutes away from the facility. -She moved 30 minutes away from the facility in February 2025. -She was in the facility twice a week at the most. -She went to the home when she had to take residents to appointments or purchase groceries for the home. -She could not be in the facility daily but could call someone she hired to manage the facility when she went on vacation. (She did not provide any information on this person.) 2. Review of Staff B's personnel record on	C 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 134	Continued From page 5 06/06/25 revealed: -Staff B was hired as a Habilitation Technician on 04/01/25. -There was no documentation of a General Education Diploma (GED) or high school diploma. -There was documentation of 12 hours of continued education credits related to management of adult care homes and care of aged and disabled persons. Interview with the Administrator/Owner on 06/06/25 at 4:20pm, 5:30pm and 6:15pm revealed: -Staff B was hired as a live in Habilitation Technician on 04/01/25. -She did not know what a Supervisor-In-Charge was. -Whoever was working was in charge in her absence. -The staff were relief staff, not permanent staff. -She did not currently have permanent staff. -It was hard to find staff. -She thought Staff B met the requirements to manage the facility. -She lived 30 minutes away from the facility. -She moved 30 minutes away from the facility in February 2025. -She was in the facility twice a week at the most. -She went to the home when she had to take residents to appointments or purchase groceries for the home. -She could not be in the facility daily but could call someone she hired to manage the facility when she went on vacation. (She did not provide any information on this person.) Attempted telephone interview with Staff B on 06/06/25 at 5:39pm was unsuccessful.	C 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 6	C 187		
C 187	10A NCAC 13G .0601 (e)(f) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (e) At all times the administrator or supervisor-in-charge shall be in the facility or within 500 feet of the facility with a means of two-way telecommunication. The administrator or supervisor-in-charge is directly responsible for assuring that all required duties are carried out in the facility and for assuring that at no time is a resident left alone in the facility without a staff member. (f) When the administrator or supervisor-in-charge are not in the facility or within 500 feet of the facility, a staff person who meets the staff qualification requirements of this Subchapter shall be on duty in the facility. The staff person shall be on duty in the facility no more than eight hours per 24 hours and no more than 24 hours total per week. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to ensure there was an Administrator, Supervisor-in-Charge (SIC), or	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 7 staff member who met the staff qualifications for SIC on site or the Administrator was at least 500 feet from the facility at all times. The findings are: Review of the facility's license revealed: -The facility was licensed effective 01/01/25 for a capacity of 6 ambulatory residents. -The expiration date of the facility's license was 12/31/25. Observation of the facility on 06/06/25 at 7:35am revealed: -There was one staff member present. -There were 4 residents preparing to leave to attend day programs. Interview of Staff A revealed: -The current census was 5 residents. -One resident had already left to go to the day program. Interview with the Administrator/Owner on 06/06/25 at 4:20pm, 5:30pm and 6:15pm revealed: -She did not know what a Supervisor-In-Charge was. -Whoever was working was in charge in her absence. -The staff were relief staff, not permanent staff. -She did not currently have permanent staff. -It was hard to find staff. -She lived 30 minutes away from the facility. -She moved 30 minutes away from the facility in February 2025. -She was in the facility twice a week at the most. -She went to the home when she had to take residents to appointments or purchase groceries for the home.	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 8 -She could not be in the facility daily but there was a staff member who managed the facility when she was on vacation that she could call. (She did not provide any information on this person.) 1. Review of Staff A's record on 06/06/25 revealed: -He was hired as a Habilitation Technician on 05/01/22. -He signed his job description on 04/15/25. -He obtained his General Educational Diploma (GED) 06/22/97. -There was a Cardiopulmonary Resuscitation (CPR) card dated 04/14/25. -He completed Diabetes Management Training 02/20/25. -He completed Medication and Insulin Administration training 02/20/25. -There was no documentation of personal care aide (PCA) training. -There were no Continuing Education Units (CEU) for the past 12 months. Review of the job description for the Habilitation Technician revealed: -The purpose was to specify the duties and requirements of a Habilitation Technician. -Policy: Each employee/contract agent would receive a description of his/her position that included duties and responsibilities and the minimum requirements for the position. -Procedure: Reports to Administrator or Associate Professional -Nature of Work: Paraprofessional level position responsible for providing residential/in-home services to clients of varying ages, diagnoses, and needs. -Duties and Responsibilities: Implement service plan, administer medication ordered by	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 9 physicians in accordance with applicable status regulations, policies, and procedures, maintain medication administration records, conduct medication administration inventories, assist clients with personal care and activities of daily living (ADL) to include bathing, dressing, feeding, toileting, assist client with participation in recreational/leisure activities, complete necessary documentation paperwork, assist with or perform meal preparation, grocery shopping, assist client with another personal care task as assigned or in accordance with client needs, other duties as assigned -Education, Training and Experience: High school diploma or GED equivalent, Certification in CPR, Standard First Aid, Valid North Carolina Driver's License if driving in North Carolina. Interview with Staff A on 06/06/25 at 7:35am and 8:25am revealed: -He introduced himself as a personal care aide (PCA) and overnight/live-in staff. -The Administrator/Owner was not present, but he would call her. -He worked alone for 2 weeks at a time, 24 hours per day, 7 days per week. -He administered medication to all residents at approximately 7:20am this morning. -He was not a medication aide (MA). -This was his first week back since May 2025. -He was a relief staff and worked as needed. Second interview with Staff A on 06/06/25 at 4:20pm and 5:52pm revealed: -His duties included cooking, cleaning, assisting residents with baths, administering medication to include insulin, and checking blood sugar levels. -He did not have any CEUs for the past 12 months. -If there was an issue, he called the Administrator	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 10 to inform her and asked what she wanted him to do. -In the event of an emergency, he called 911 first. -He did not have an issue reaching the Administrator when he needed her. Interview with the Administrator/Owner on 06/06/25 at 4:20pm revealed: -Staff A was hired as a live in Habilitation Technician on 05/01/22. -Staff A just came back to work for her April 2025. 2. Review of Staff B's record on 06/06/25 revealed: -He was hired as a Habilitation Technician on 04/01/25. -He signed his job description on 04/04/25. -There was a Cardiopulmonary Resuscitation (CPR) card dated 08/15/24. -He completed 12 hours of Continuing Education Units (CEU). -There was no documentation of a high school diploma or General Educational Diploma (GED) in the record. Review of the job description for the Habilitation Technician revealed: -The purpose was to specify the duties and requirements of a Habilitation Technician. -Policy: Each employee/contract agent would receive a description of his/her position that included duties and responsibilities and the minimum requirements for the position. -Procedure: Reports to Administrator or Associate Professional -Nature of Work: Paraprofessional level position responsible for providing residential/in-home services to clients of varying ages, diagnoses, and needs. -Duties and Responsibilities: Implement service	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 11 plan, administer medication ordered by physicians in accordance with applicable status regulations, policies, and procedures, maintain medication administration records, conduct medication administration inventories, assist clients with personal care and activities of daily living (ADL) to include bathing, dressing, feeding, toileting, assist client with participation in recreational/leisure activities, complete necessary documentation paperwork, assist with or perform meal preparation, grocery shopping, assist client with another personal care task as assigned or in accordance with client needs, other duties as assigned -Education, Training and Experience: High school diploma or GED equivalent, Certification in CPR, Standard First Aid, Valid North Carolina Driver's License if driving in North Carolina. Interview with the Administrator/Owner on 06/06/25 at 4:20pm revealed: -Staff B was hired as a live in Habilitation Technician on 04/01/25. -Staff B was not working this week. Attempted telephone interview with Staff B on 06/06/25 at 5:39pm was unsuccessful. Non compliance was identified in the following rule areas: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff B) who administered medications had completed the state-approved 5-hour,10-hour, or 15-hour medication aide (MA) training courses and the Medication Administration Competency Validation Clinical Skills Checklist as required. [Refer to tag 131, 10A NCAC 13G .0403(a) Qualifications of Medication Staff.]	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 187	Continued From page 12 Based on record reviews and interviews, the Administrator failed to ensure the supervisor-in-charge earned 12 hours of yearly continued education credits related to management of adult care homes and care of aged and disabled persons. [Refe to tag 134, 10A NCAC 13G .0402 Qualifications of Supervisor-in-Charge.] The facility failed to ensure there was an Administrator, Supervisor-in-Charge (SIC), or staff member who met the staff qualifications for SIC on site or the Administrator was at least 500 feet from the facility at all times to carry out all required duties in the facility. Staff were hired to work 2 weeks at a times as live-in Habilitation Technicians and did not meet the requirements of Supervisor-In-Charge. The Administrator lived 30 minutes away and visited the facilty no more than 2 days per week. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 8, 2025.	C 187		
C 218	10A NCAC 13G .0704 (b) Resident Contract, Information on Facility 10A NCAC 13G .0704 Resident Contract, Information On Facility, and Resident Register (b) A family care home's administrator or supervisor-in-charge and the resident or the	C 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 218	Continued From page 13	C 218		

resident's responsible person shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following:

(1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address;

(2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;

(3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests;

(4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail;

(5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D- 4.8; and

(6) resident's consent including a signature confirming the review and receipt of information contained in the form.

The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf, at no charge. The facility may use a resident information form other than the Resident Register as long as it contains same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 218	Continued From page 14 the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed and signed for 1 of 3 residents sampled (#3). The findings are: Review of Resident #3's current FL-2 dated 06/05/25 revealed: -Diagnoses included paranoid schizophrenia, acute psychosis, non-compliance with medication, agitation, psychogenic tremors and chronic kidney disease. -There was an admission date of 04/26/25. Review of Resident #3's record revealed there was no Resident Register. Observation of the Administrator/Owner between 2:30 and 2:50pm revealed she completed Resident #3's Resident Register while sitting at the table with the surveyor. Interview with the Administrator/Owner on 06/06/25 at 12:00pm revealed: -She was responsible for completing the Resident Register. -All the residents in the facility had their Resident Registers completed. -She thought she left Resident #3's Resident Register on her printer at home. -She could not find Resident #3's Resident Register.	C 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were documented immediately after administration and not pre-charted before administration for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 12/16/24 revealed: -Diagnoses included type 2 diabetes, hypertension, hyperlipidemia, asthma, seasonal allergies, severe intellectual disability, impulse control, and disruptive mood dysregulation disorder. -There was an order for Certavite SR tab daily. (Certavite is used to prevent vitamin deficiency.) -There was an order for Aspirin 81mg daily. (Aspirin is used to treat heart health.) -There was an order for Risperidone 1mg daily. (Risperidone is used to treat mental health conditions.)	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 341	Continued From page 16 -There was an order for Lisinopril 5mg daily. (Lisinopril is used to treat high blood pressure.) -There was an order for Vitamin D3 2000iu daily. (Vitamin D3 is used to treat Vitamin D deficiency.) -There was an order for Metformin HCL 1000mg twice daily. (Metformin is used to treat type 2 diabetes.) Review of physician's orders revealed: -There was an order dated 03/04/25 for Trazadone 100mg nightly. (Trazadone is used to treat major depressive disorder.) -There was an order dated 11/22/24 for Atorvastatin 20mg 1 tablet daily. (Atorvastatin is used to treat high cholesterol.) -There was an order dated 04/22/25 for Humalog Kwikpen 100u/ml inject 15 units 3 times daily. (Humalog is used to treat diabetes.) -There was an order dated 04/11/25 for Qvar Redihaler 40mcg inhale 2 puffs twice daily. (Qvar is used to treat asthma.) Review of Resident #2's June 2025 medication administration record (MAR) revealed: -There was an entry for Certavite Multivitamin Plus once daily with a scheduled administration time of 8:00am. -There was documentation that Certavite was administered daily from 06/01/25-06/07/25 at 8:00am. -There was an entry for Aspirin 81mg once daily with a scheduled administration time of 8:00am. -There was documentation that Aspirin was administered daily from 06/01/25-06/07/25 at 8:00am. -There was an entry for Risperidone 1mg daily with a scheduled administration time of 8:00am. -There was documentation that Risperidone was administered daily from 06/01/25-06/07/25 at 8:00am.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 341	Continued From page 17 -There was an entry for Lisinopril 40mg once daily with a scheduled administration time of 8:00am. -There was documentation Lisinopril was administered daily from 06/01/25-06/07/25 at 8:00am. -There was an entry for Vitamin D3 2000iu daily with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 was administered daily from 06/01/25-06/07/25 at 8:00am. -There was an entry for Metformin HCL 1000mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Metformin was administered daily from 06/01/25-06/07/25 at 8:00am and 06/01/25-06/06/25 at 8:00pm. -There was an entry for Atorvastatin 20mg once daily with a scheduled administration time of 8:00am. -There was documentation Atorvastatin was administered daily from 06/01/25-06/07/25 at 8:00am. -There was an entry for Humalog Kwikpen 100u/ml inject 15 units 3 times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation Humalog was administered daily from 06/01/25-06/07/25 at 8:00am and 2:00pm and 06/01/25-06/06/25 at 8:00pm. -There was an entry for Qvar Redihaler 40mcg inhale 2 puffs twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Qvar was administered daily from 06/01/25-06/07/25 at 8:00am and 06/01/25-06/06/25 at 8:00pm. Interview with Staff A on 06/06/25 at 8:25am, 11:36am and 3:15pm revealed: -He was responsible for administering	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 341	Continued From page 18	C 341		

medication.
-Residents came to the table off the kitchen to get their medication.
-When administering medications to residents, he called the resident's name, opened the medication and watched the resident take the medication.
-He used the MAR to administer medications by comparing the medications on the MAR with the medications on the cart.
-He was responsible for documenting on the MAR.
-After administering medication, he waited until around 11:00am or until all the residents left the facility to sit down and document medications administered on the MAR.
-He was aware medications were to be documented immediately after administration.
-He became distracted with charting when residents came to ask him questions.
-He did not document immediately after administering medication because he was trying to get the residents ready to get on their buses for the day programs.
-He thought today (06/06/25) was 06/07/25 and that was why he documented medications as being administered for 06/07/25.

Interview with the Administrator/Owner on 06/06/25 at 11:36am and 3:12pm revealed:
-The staff administering medication was responsible for documenting on the MAR.
-Medication administration should have been documented immediately after the medication was administered.
-She was not aware medications were already documented as administered for 8:00pm today (06/06/25) and tomorrow (06/07/25).
-If medications were documented immediately after administration, residents would miss their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 341	Continued From page 19 bus to the day program. -She checked MARs monthly but did not check MARs in May 2025 because she was sick.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medication administration records (MAR) were complete and accurate for 2 of 3 sampled residents related to medications for high blood pressure (#1) and asthma (#2) that was being administered but not documented on the MAR.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 342	Continued From page 20 The findings are: 1. Review of Resident #1's current FL-2 dated 12/16/24 revealed: -Diagnoses included hypertension, stroke, cardiac arrest with ventricular fibrillation, coronary artery disease, hemiplegia and hemiparesis. -There was an order for Terazosin 2mg nightly. (Terazosin is used to treat high blood pressure.) Review of Resident #1's Resident Register revealed she was admitted on 11/22/24. Observation of Resident #1's medications on hand on 06/06/25 at 2:00pm revealed: -Terazosin 2mg tablets were packaged in multidose packs with other medications. -There were no multidose packs for May 2025 left on the cart. -There were multidose packs left for the evening of 06/06/25 through 06/17/25. Review of Resident #1's medication administration record (MAR) for May 2025 revealed: -There was an entry for Terazosin 2mg capsule take one capsule at bedtime. -There was no documentation of Terazosin being administered for 05/01/25 through 05/31/25 as the spaces were blank. -There was no documentation on the exceptions page for the blank spaces. Interview with Staff A on 06/06/25 at 11:36am and 1:55pm revealed: -He administered the Terazosin nightly from 06/06/25 to 06/16/25. -Terazosin came in a multidose pack so the medication had been administered with the other	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 342	Continued From page 21	C 342		

medications in the pack.
-He was unsure how the whole month of May 2025 was left blank for administration of Terazosin and not caught by anyone.

Interview with the Administrator/Owner on 06/06/25 at 11:32am and 3:15pm revealed:
-She was not aware the whole month of May 2025 was blank for administration of Terazosin.
-Staff did not document when they administered Terazosin.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/06/25 at 1:31pm revealed:
-There was a refill order dated 05/07/25 for Terazosin 2mg, 1 capsule at bedtime.
-The order did not specify what Terazosin was prescribed for, but Terazosin was usually prescribed for hypertension.
-Terazosin was dispensed on a monthly cycle.
-Terazosin was dispensed in a pack with other pills and was not individually packaged.
-Terazosin was dispensed 04/17/25 and delivered 04/23/25.
-Terazosin was dispensed 05/17/25 and delivered 05/23/25.

Attempted telephone interview with the primary care provider (PCP) on 06/06/25 at 3:53pm was unsuccessful.

Refer to interview with Staff A on 06/06/25 at 11:36am and 1:55pm.

Refer to interview with the Administrator/Owner on 06/06/25 at 11:32am and 3:15pm.

2. Review of Resident #2's current FL-2 dated 12/16/24 revealed diagnoses included type 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 342	Continued From page 22 diabetes, hypertension, asthma, seasonal allergies, hyperlipidemia and severe intellectual disability. Review of Resident #2's Resident Register revealed she was admitted on 06/22/22. Review of a Resident #2's physician's order dated 04/11/25 revealed an order for Qvar Redihaler 40mcg inhale 2 puffs twice daily. (Qvar is used to treat asthma.) Observation of Resident #2's medications on hand on 06/06/25 at 2:00pm revealed there was 1 inhaler dispensed 04/17/25 and 1 inhaler dispensed 05/17/25. Review of Resident #2's medication administration record (MAR) for May 2025 revealed: -There was an entry for Qvar Redihaler 40mcg inhale 2 puffs twice daily. -There was no documentation of Qvar Redihaler being administered for 05/01/25 through 05/31/25 as the spaces were blank. -There was no documentation on the exceptions page for the blank spaces. Interview with the Staff A on 06/06/25 at 11:36am and 1:55pm revealed: -He administered the Qvar 05/06/25 through 05/16/25. -He was unsure how the whole month of May was left blank for administration of Qvar and not caught by anyone. Interview with the Administrator/Owner on 06/06/25 at 11:32am and 3:15pm revealed: -She was not aware the whole month of May 2025 was blank for administration of Qvar.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 342	Continued From page 23 -Staff did not document when they administered Qvar. Refer to interview with Staff A on 06/06/25 at 11:36am and 1:55pm. Refer to interview with the Administrator/Owner on 06/06/25 at 11:32am and 3:15pm. _____ Interview with Staff A on 06/06/25 at 11:36am and 1:55pm revealed: -He was responsible for administering medication. -When administering medications to residents, he called the resident's name, opened the medication and watched the resident take the medication. -He used the MAR to administer medications by comparing the medications on the MAR with the medications on the cart. -He did not realize he had not documented the medication as administered on the MAR. -He did not usually leave blank spaces on the MAR. -He did review the MAR after being off. -Staff checked the MAR behind each other when they returned to work after being off. Interview with the Administrator/Owner on 06/06/25 at 11:32am and 3:15pm revealed: -Staff that administered medication were responsible for documenting on the MAR. -The staff who administered the medication was supposed to administer the medication and document all the medications in the multidose pack as administered on the MAR. -She checked MARs monthly but did not check MARs in May 2025 because she was sick. -Staff had to recopy the May 2025 MAR because the original MAR was damaged by liquid.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092289	A. BUILDING: _____ B. WING _____	R 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES 2	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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) COMPLETE DATE
C 342	Continued From page 24 -The medication was administered because it came in a multidose pack with other medications.	C 342		