Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 000	INITIAL COMMENTS An annual survey was completed on March 11, 2026. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000	What the Rule Requires **10A NCAC 27G .0201(a)(1–7)** requires the governing body to develop, implement, and enforce written policies that include: Admission and discharge procedures Admission assessments and screenings Determination of whether the facility can meet client needs Client record management Quality Assurance/Performance Improvement (QAPI) Adoption of standards that ensure care meets accepted standards of practice Clinical oversight and supervision	04/03/2026
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	**PLAN OF CORRECTION** 1. **Immediate Corrective Actions** All current clients have received comprehensive admission assessments and screenings completed by the Qualified Professional (QP). The facility has applied for a CLIA waiver to ensure compliance with federal requirements for clinical testing. Pending CLIA approval: All laboratory testing is either: Conducted by appropriately licensed personnel, or Referred to an external licensed provider **2. Policy Revision and Implementation** **A. Admission Policy (REVISED)** The governing body is revising the Admission Policy to require: -Pre-admission screening and assessment MUST be completed prior to admission -Assessment must include: -Presenting problems -Needs and strengths -Medical and psychiatric history -Determination of appropriateness for placement	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ifeoma Umelo — Owner — 04/13/26
TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105	Policy being Implemented: -No client may be admitted without: -Completed QP assessment -RN review (if medical needs present) -Approval by Facility Director **B. Clinical Testing / CLIA Compliance Policy** A policy is being developed and will be implemented requiring: -No point-of-care testing (e.g., glucose monitoring, urine drug screens) will be performed unless: The facility holds a valid CLIA waiver, AND -Staff are trained and competency-validated -If CLIA waiver is not active: Testing must be performed by: Licensed providers, or External certified laboratories C**. Quality Assurance / Performance Improvement** (QAPI) Policy (REVISED) -A formal QAPI program has been implemented that includes: -Monthly review of admissions -Clinical compliance monitoring -Review of laboratory/testing practices -Documentation audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to 1) implement their admission policy affecting 2 of 3 audited current clients (#5 and #6) and 1 of 1 Former Client (FC #8) and 2) develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of Urine Drug Screen Testing including the Clinical Laboratory Improvement Amendment (CLIA) waiver. The findings are: Finding #1: Review on 02/24/26 of the facility's admission criteria policy revealed: -"A. Twinkle-Star Qualified Professionals, Administrator, or his designees will be allowed to admit clients to these services after reviewing all materials from the referral source…The client assessment will be completed in no more than 72 hours. Person centered, family focused methods will be used to identify life outcomes and determine strategies for achieving outcome …" Review on 02/24/26 and 02/27/26 of client #6's record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major Depressive Disorder, Anxiety, Aphasia and Dysphasia. -No documentation in client's record to show a screening or assessment of the client's needs, and if the facility could provide services or the disposition with recommendations to this facility. Review on 02/24/26 and 02/25/26 of client #5's	V 105	**Implementation Measures** -Admission Checklist System implemented -Must be completed and signed prior to admission -Policy Manual updated -All revised policies distributed to staff -Staff trained on new policies prior to implementation **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: -Admission control system enforced -No testing without CLIA compliance **Policies require:** -Documentation verification prior to service delivery **Any deviation will result in:** -Immediate corrective action -Staff retraining **MONITORING** (First 90 Days) 100% review of all admissions **Weekly audits of:** -Admission assessments -Screening documentation -Testing practices **Ongoing** -Monthly QAPI audits -Random chart reviews -CLIA compliance verification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 105	Continued From page 3 record revealed: -Admission date of 02/03/26. -Diagnoses of Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease (GERD), Diabetes Type 2, Allergic Rhinitis and Pruritis Rash -No documentation of a screening or assessment of the client's needs, and if the facility could provide services or the disposition with recommendations to this facility. Review on 02/27/26 of FC #8's record revealed: -Admission date of 02/03/26. -Schizophrenia Post-Traumatic Stress Disorder, Diabetes, Anxiety Disorder, GERD, Hyperlipidemia, Low B12 and Vitamin D. -Discharge date of 02/04/26. -No documentation of a screening or assessment of the client's needs, and if the facility could provide services or the disposition with recommendations to this facility. Finding #2: Review on 02/26/26 of the Division of Health Service Regulation records revealed no CLIA waiver to include finger stick blood sugar testing. Review on 02/27/26 of client #6's physician orders dated 11/05/25 revealed: -Humalog (insulin) 6 units - 4 times a day with meals and hold for a blood sugar value less than 110. Review on 02/24/26 of client #6's documented blood sugar values from 02/03/26 thru 02/17/26 revealed: -Blood sugar values were documented 55 times. Review on 02/26/26 of a glucometer labeled with	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 105	Continued From page 4 client #6's name revealed the following dates and times of fasting stick blood sugar (FSBS) results for the past 30 days revealed: -02/10/26 at 11:31am - "HI" (per manufacture "HI" means not able to read results). -02/14/26 at 8:22am - 378. -02/14/26 at 8:25am - 354. Interview on 02/24/26 and 02/27/26 staff #1 stated: -He checked client #6's blood sugar 4 times a day unless client #6 was at the day program. -He used a glucometer labeled with client #6's name. -He documented the blood sugar values. -Client #6 did not check blood sugar values. Interview on 02/27/26 and 03/04/26 the Licensee/Registered Nurse (RN) stated: -An admission assessment should be completed prior to admission. -The policy indicated an admission assessment should be completed in no more than 72 hours. -She had admitted client #5 and client #6 on an "emergency" basis on 02/03/26. -Client #5 and client #6 were brought to the facility in the early morning hours of 02/03/26. -FC #8 was admitted on 02/03/26 and discharged to a sister facility on 02/04/26. -She had not completed an admission assessment for client #5, client #6 or FC #8. -She took responsibility for no admission assessments completed. -Staff performed finger stick blood sugar checks 4 times a day for client #6. -She did not have a CLIA waiver for the facility to allow blood sugar testing. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 105	Continued From page 5 violation and must be corrected within 23 days	V 105	**V107 – 10A NCAC 27G .0202(a–e)** **Personnel Requirements** **What the Rule Requires**	04/03/2026
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the	V 107	**10A NCAC 27G .0202(**a–e) requires that: Each staff member must have a complete personnel record maintained by the facility, including: Written job description (signed by employee and supervisor) Documentation of qualifications (education, experience, competency) Verification of credentials/licensure (if applicable) The facility must ensure all staff: Meet minimum qualifications for their position Are at least 18 years old Are able to perform assigned duties Have no disqualifying findings on the Health Care Personnel Registry (HCPR) All applicants must disclose criminal convictions, and background checks must be completed prior to employment **PLAN OF CORRECTION** **1. Immediate Corrective Actions** The facility is conducting a 100% audit of all current staff personnel records to ensure compliance with 10A NCAC 27G .0202(a–e). Any missing documentation in current staff files will be obtained and filed. The facility has implemented a policy that no individual, including temporary or "shadow" staff, may work in the facility without a complete personnel record. 2**. Policy Revision and Implementation** A. Personnel Records Policy (REVISED)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 107	Continued From page 6 services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have a complete personnel record for 1 of 1 Former Staff (FS #5). The findings are: Review on 03/11/26 of facility records revealed: -No personnel record for FS #5. -No date of hire documented. -No written job description, no documentation of minimum level of education, competency, work experience, skills and other required qualifications for the position. -No personnel record maintained which indicated the training, experience and other qualifications for the position. Attempted interview on 03/11/26 with FS #5 was unsuccessful after a detailed message was left to return phone call with no response. Interview on 03/11/26 the Qualified Professional stated: -Not aware there was any other staff who worked at the facility with staff #1, "only [staff #1]."	V 107	**The governing body is revising the Personnel Policy to require that a complete personnel file must be established prior to any staff providing services, including:** Signed job description Completed application Verification of education and qualifications Background check (criminal) Health Care Personnel Registry (HCPR) verification Documentation of training and competencies **Employment Policy Implemented:** No staff may: Work Shadow Volunteer in a direct care capacity WITHOUT a fully completed and verified personnel file B. **Hiring and Pre-Employment Verification Process** A standardized Pre-Employment Checklist is being implemented requiring: HCPR check (verified and documented) Criminal background check Verification of qualifications Review and signing of job description Administrator approval prior to first shift C. Personnel File Organization System (NEW) Each employee file is now maintained in a standardized format with labeled sections: Employment documents Credentials Training records Background checks Files are maintained on-site and available for review at all times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 107	Continued From page 7 Interview on 03/11/26 the Licensee/Registered Nurse stated: -FS #5 was a "shadow staff." -FS #5 was at the facility to "shadow" staff #1. -She had not hired FS #5. -FS #5 worked at the facility for several days in February 2026. -Staff #1 and FS #5 were at the facility when she came on 02/22/26, after Emergency Management Services transported client #6 to hospital. -FS #5 no longer worked at the facility. -She paid FS #5 for her work at the facility, "I paid her yes not working but shadowing..." -She did not have a personnel record or training for FS #5. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 107	**3. Implementation Measures** All staff files are reviewed prior to scheduling Administrator verifies file completeness before allowing staff to work Personnel file checklist placed at the front of each file for ongoing compliance **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Hiring policy enforced (no file = no work) No exceptions for: Shadow staff Temporary staff Contract staff All personnel actions require documentation prior to start date Any missing documentation will result in: Immediate removal from schedule Corrective action **MONITORING** (First 90 Days) Weekly audit of 100% of personnel files Verification of: Required documentation Background checks Job descriptions **Ongoing** Monthly personnel file audits Random file checks by governing body Documentation of all audits maintained for review	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G	V 108	**V108 – 10A NCAC 27G .0202(f–i)** **Personnel Training Requirements** **What the Rule Requires** 10A NCAC 27G .0202(f–i) requires that: All staff must receive training prior to providing services and must demonstrate competency. Required training includes: Client rights (27E rules) Confidentiality Infection control and bloodborne pathogens	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 108	Continued From page 8 .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 Former Staff (FS #5) had the minimum employee trainings. The findings are: Review on 03/11/26 of facility records revealed: -No personnel record for FS #5. -No date of hire documented. -No documentation of the following: general organizational orientation, training on client rights and confidentiality, training to meet the Mental Health/Developmental Disability/Substance Abuse needs of the client as specified in the treatment/habilitation plan or training in infectious diseases and bloodborne pathogens. Attempted interview on 03/11/26 with FS #5 was	V 108	Emergency procedures Population-specific care needs Staff must: Be trained before working independently Have documentation of all training maintained in personnel records The governing body must ensure: Training is completed, documented, and updated Staff are competent to perform assigned duties **PLAN OF CORRECTION** 1. Immediate Corrective Actions A 100% audit of all staff training records is in progress. All current staff are completing required training, including: Client rights Infection control Emergency procedures Job-specific duties Any staff without complete training were: 2. Policy Revision A. Staff Training Policy (REVISED) The governing body is revising the Training Policy to require: All staff must complete: Orientation training Required regulatory training Job-specific training Training must occur: Before working independently Annually thereafter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 108	Continued From page 9 unsuccessful after a detailed message was left to return the phone call with no response. Interview on 03/11/26 the Qualified Professional stated: -Not aware there was any other staff who worked at the facility with staff #1, "only [staff #1]." Interview on 03/11/26 the Licensee/Registered Nurse stated: -FS #5 was a "shadow staff." -FS #5 was at the facility to "shadow" staff #1. -She had not hired FS #5. -FS #5 worked at the facility for several days in February 2026. -FS #5 no longer worked at the facility. -She paid FS #5 for her work. -She did not have any personnel record or training for FS #5. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 108	Training Policy Implemented: **No staff may:** Work independently Provide direct care **WITHOUT:** -Completed required training -Documented competency validation **B. Training Program and Curriculum** A structured training program is being implemented including: Core Training Modules: Client Rights (27E) Infection Control Emergency Procedures Documentation standards PCP implementation Population-Specific Training: Mental health needs ADLs and supervision **C. Training Tracking System** **A Training Log and Tracking System is being implemented to monitor:** Completion dates Expiration dates Required renewals Training records are maintained in personnel files 3**. Implementation Measures** Facility Director verifies training completion before scheduling staff Competency validation required for all staff Training sign-in sheets and competency forms maintained	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by	V 109		

			PREVENTION OF RECURRENCE To ensure this deficiency does not recur: **Training tracking system alerts for:** -Expiring certifications- -Any missing training will result in: -Immediate removal from schedule -Retraining **MONITORING** (First 90 Days) Weekly review of all training records **Verification that:** Training is complete Competency is documented Ongoing Monthly training audits through QAPI Random personnel file reviews Documentation maintained for survey review	
			V109 – 10A NCAC 27G .0203 **Competencies of Qualified Professionals and Associate Professionals** **What the Rule Requires** 10A NCAC 27G .0203 requires that: Qualified Professionals (QP) and Associate Professionals must demonstrate the knowledge, skills, and abilities necessary to serve the population. Competency includes: Clinical/technical knowledge Assessment and treatment planning Decision-making and problem-solving Communication and interpersonal skills Supervision of staff The governing body must ensure: Appropriate clinical oversight and supervision Competency is demonstrated and maintained Supervision plans are implemented for associate professionals	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4	24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 109	Continued From page 10 exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 2 of 2 Qualified Professionals (QP) and Licensee/Registered Nurse (RN) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record reviews and interview, the facility failed to 1) implement their admission	V 109	**PLAN OF CORRECTION** 1. Immediate Corrective Actions **The facility has implemented a new governing and clinical oversight structure, including:** **Consultant RN (clinical oversight)** **Qualified Professional (service oversight)** **Facility Director (administrative oversight)** All client records, assessments, and Person-Centered Plans are being reviewed and corrected. An external Qualified Professional has been engaged to provide immediate training and supervision. 2. **Policy Revision and Implementation** **A. QP Competency and Supervision Policy** The governing body is developing and implementing a policy requiring: -All QPs must demonstrate competency in: -Admission and assessment processes -Person-Centered Planning -Documentation standards -Coordination of care: -Weekly supervision meetings (first 90 days) -Ongoing monthly supervision thereafter **B. Clinical Oversight Policy (REVISED)** The QP is responsible for: Ensuring all assessments are completed prior to service delivery Developing and reviewing PCPs Supervising staff providing direct care The Consultant RN provides: Clinical guidance and oversight Review of medical-related services and documentation C. Competency Validation Process (NEW) A structured competency validation process has been implemented requiring: Review of completed assessments and PCPs Direct observation of QP performance Case review and documentation audits Written and practical competency evaluation 3**. Implementation Measures** Weekly case reviews conducted by QP and Consultant RN All clinical documentation reviewed for accuracy and completeness Supervision logs maintained and signed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	**2409 BEL AIR AVENUE SE WILSON, NC 27893**

(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
V 109	Continued From page 11 policy affecting 2 of 3 audited current clients (#5 and #6) and 1 of 1 Former Client (FC #8) and 2) develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of Urine Drug Screen Testing including the CLIA (Clinical Laboratory Improvement Amendment) waiver. Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V107). Based on record review and interviews, the facility failed to have complete personnel record for 1 of 1 Former Staff (FS #5). Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview the facility failed to ensure 1 of 1 Former Staff (FS #5) had the minimum employee trainings. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to ensure an assessment was completed for 2 of 3 audited current clients (#5 and #6) and 1 of 1 Former Clients (FC #8) prior to the delivery of services. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record reviews and interviews, the facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (#1). Cross Reference: 10A NCAC 27G .0206 Client Records (V113).	V 109	**PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: -No QP will function independently without validated competency -All clinical functions (assessment, PCP, documentation) require: -Review and approval -Ongoing supervision is required and documented -Any identified deficiency will result in: Immediate retraining -Increased supervision **MONITORING** (First 90 Days) Weekly audits of: Assessments PCPs Documentation Weekly supervision meetings documented **Ongoing** Monthly clinical audits Quarterly competency evaluations of QP Governing body review of QP performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 109	Continued From page 12 Based on record review and interview, the facility failed to maintain complete client records affecting 1 of 1 Former Client (FC #8). Cross Reference: G.S. §131E-256 Health Care Personnel Registry (V131). Based on record review and interview the facility failed to complete Health Care Personnel Registry (HCPR) check prior to hire for 1 of 1 Former Staff (FS #5). Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals responsible for the client's treatment affecting 2 of 3 audited clients (#1 and #6). Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536). Based on record reviews and interviews the facility failed to ensure 1 of 3 current staff (Qualified Professional (QP)) and 1 of 1 Former Staff (FS #5) had annual or initial refresher training in alternatives to restrictive intervention. Cross Reference: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537). Based on record reviews and interviews, the facility failed to ensure 1 of 3 current staff (Qualified Professional (QP)) and 1 of 1 Former Staff (FS #5) received annual or initial training in seclusion, physical restraint and isolation time out. Review on 02/25/26 of the QP's personnel record revealed:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 109	Continued From page 13 -Date of hire: 12/12/24. Review on 02/25/26 of the Licensee/RN's personnel record revealed: -Date of hire: 12/12/24. Interview on 03/11/26 the QP stated: -She was not aware of some of the issues addressed at exit. Interviews on 2/27/26 and 03/11/26 the Licensee/RN stated: -"I do make the final decision for all placements and for all all admissions..." -She would coordinate with another QP to provide training. Review on 03/11/26 of the Plan of Protection (POP) dated 03/11/26 and written by the Licensee/RN and QP revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? The facility will contract with another QP to provide training to the assigned QP, Administrator (Licensee/RN), any Associate Professionals, direct care & other employees providing direct services to the clients. - The CLIA waiver will be applied for in the next 24 hrs. (hours). All person centered plans will be updated to address current needs. All employee files will be reviewed and training needs will be met within 72 hours. QP will ensure that any medication orders that require administration outside of hours in the facility are modified by prescribing person. -Describe your plans to make sure the above happens. The contracted QP will oversee the above and meet assigned QP and Administrator to discuss progress and outcomes of any training, coordination and monitoring of clients and	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 109	Continued From page 14 services." Review on 03/11/26 of the Amended POP dated 03/11/26 and written by the Licensee/RN and QP revealed, "107/108 The facility administrator will ensure that any staff person hired to work in this facility will meet personnel requirements by ensuring that they have educational requirements, CPR/First Aid (Cardiopulmonary Resuscitation), NCI Plus (National Crisis Intervention) , Diabetes care and management, insulin administration, medication administration and all other train-ing that have been identified to meet client needs. 111 - The admission assessment will be completed after the QP and Administrator agree upon admission that assessment will address all needs, recommendations, precautions and strategies needed in order to provide treatment and training to meet client needs. 113 - The Administrator will ensure that any and all clients that are admitted to this facility are provided with a record. that record will contain referral information, FL-2, Admission Assessment, consents upon admission. All other information obtained during that ad-mission will be stored in that record. The record will be kept in entirety on the premises. 131 - The facility Administrator will complete the HCPR check as well as a criminal back-ground check prior to allowing that person to work. 536/537 Ensure that any new hire volunteer receives all required, All training will be monitored for completion." This facility is licensed for 6 clients with diagnoses to include Dementia, Left Leg Below Knee Amputation, Paranoid Schizophrenia, Paraplegia, Cognitive Impairment, Bowel Incontinence, Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed and Depressed Mood, Substance Use, Major	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 109	Continued From page 15 Depressive Affective Disorder, Unspecified Intellectual Disability, Hypertension, Obesity, Unspecified Anxiety Disorder, Unspecified Psychosis, Muscle Weakness, Generalized Pain, Aphasia, Dysphasia, Post-Traumatic Stress Disorder, Diabetes Mellitus, Gastroesophageal Reflux Disease, Hyperlipidemia, Low B12 and Vitamin D, History of Hypothermia. Client #5, #6 and FC #8 had no admission assessments or screening assessments. Staff performed blood sugar checks and no CLIA waiver had been applied for. FS #5 worked at the facility for several days in February 2026 without the appropriate client centered training to meet the client needs, had no personnel record or HCPR check. No record had been completed for FC #5. Client #1's assessed needs of hygiene care and response to emergencies were not addressed in his treatment plan. The Qualified Professionals responsible for client #1's care did not coordinate with the day program regarding the medication administration for client #1. The QP and FS #5 did not have the required NCI training to ensure the needs and safety of the clients being served. The QP and Licensee/RN oversaw systemic deficient areas which neglected the daily needs of the clients in the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not	V 111	**V111 – 10A NCAC 27G .0205 (A–B) Assessment and Treatment/Habilitation or Service Plan (Assessment Requirement)** **What the Rule Requires** 10A NCAC 27G .0205 (A–B) requires that: An assessment must be completed prior to the delivery of services. The assessment must include, at minimum: Presenting problem Needs and strengths Provisional/admitting diagnosis Social, family, and medical history Relevant evaluations (medical, psychiatric, etc.) If services are provided prior to completion of a full	04/03/2026

			plan, interim strategies must be documented to address the client's immediate needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 111	Continued From page 16 be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment or screening was completed for 2 of 3 audited current clients (#5 and #6) and 1 of 1 Former Client (FC #8) prior to the delivery of services. The findings are: Review on 02/24/26 and 02/27/26 of client #6's record revealed:	V 111	**PLAN OF CORRECTION** 1. **Immediate Corrective Actions** -All current clients are in the process of receiving a comprehensive assessment completed by the Qualified Professional (QP). Missing assessment components (medical history, diagnoses, needs, and risks) are being obtained and documented. Person-Centered Plans (PCPs) are being updated to reflect the completed assessments. **2. Policy Revision and Implementation** A. Assessment and Admission Policy (REVISED) The governing body is revising the Assessment Policy to require: A complete assessment MUST be performed prior to admission and prior to delivery of any services. The assessment must include all required components outlined in 10A NCAC 27G .0205. **Policy Implemented:** No client may: Be admitted Receive services WITHOUT a completed and documented assessment by the Qualified Professional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	**2409 BEL AIR AVENUE SE WILSON, NC 27893**

(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
V 111	Continued From page 17 -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major Depressive Disorder, Anxiety, Aphasia and Dysphasia. -No evidence that an admission assessment or screening was completed prior to the delivery of services to include: presenting problems, needs, strengths, strategies or pertinent social, family and medical history. Review on 02/24/26 and 02/25/26 of client #5's record revealed: -Admission date of 02/03/26. -Diagnoses of Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease (GERD), Diabetes type 2, Allergic Rhinitis and Pruritis Rash. -No evidence that an admission assessment or screening was completed prior to the delivery of services to include: presenting problems, needs, strengths, strategies or pertinent social, family and medical history. Review on 02/27/26 of FC #8's record revealed: -Admission date of 02/03/26. -Schizophrenia Post-Traumatic Stress Disorder, Diabetes, Anxiety Disorder, GERD, Hyperlipidemia, Low B12 and Vitamin D. -Discharge date of 02/04/26. -No evidence that an admission assessment was completed prior to the delivery of services to include: presenting problems, needs, strengths, strategies or pertinent social, family and medical history. Interview on 02/27/26 and 03/04/26 the Licensee/Registered Nurse stated: -She had admitted FC #8 and client #6 on an "emergency" basis on 02/03/26.	V 111	**B. Standardized Assessment Tool** **The facility is implementing a structured assessment form requiring documentation of:** Presenting problem Mental health and medical diagnoses Strengths and support needs Social and family history Risk factors (medical, behavioral, mobility) Initial service strategies **C. Admission Checklist System (NEW)** A mandatory Admission Checklist is being implemented to verify: Assessment completed prior to admission Required documentation present QP and Facility Director approval 3. Implementation Measures -All admissions require QP completion and signature of assessment prior to entry -Facility Director must verify completion before approving admission -Assessment forms are maintained in the client record and reviewed during audits **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Admission policy enforced (no assessment = no admission/services) Standardized assessment tool ensures all required components are completed Admission checklist required and reviewed prior to admission Any missing or incomplete assessment will result in: Immediate correction Staff retraining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 111	Continued From page 18 -Client #5 and FC #8 were brought to the facility in the early morning hours of 02/03/26. -FC #8 was admitted on 02/03/26 and discharged to a sister facility on 02/4/26. -She had not completed an admission assessment or screening for client #5, client #6 or FC #8. -She took responsibility for no completed admission assessments or screenings for the above clients. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 111	MONITORING (First 90 Days) 100% review of all new admissions Weekly audits of: Assessment completion Required components present Proper signatures and dates **Ongoing** Monthly chart audits through QAPI Random record reviews by governing body Documentation of all audit findings maintained	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the	V 112	**V112 – 10A NCAC 27G .0205 (C–D) Assessment and Treatment/Habilitation or Service Plan (Person-Centered Plan Requirements)** **What the Rule Requires** 10A NCAC 27G .0205 (C–D) requires that: A treatment/habilitation (Person-Centered Plan - PCP) must be: Developed based on the assessment Completed within 30 days of admission Developed in partnership with the client or legally responsible person The plan must include: Measurable goals/outcomes Strategies to address identified needs Staff responsible for implementation Timeframes for review Methods for evaluating progress Client or guardian consent	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 112	Continued From page 19 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (#1). The findings are: Review on 02/24/26 of client #1's record revealed: -Admission date of 10/28/25. -Diagnoses of Dementia, Left Below the Knee Amputation, Paraplegia, Schizoaffective Disorder, Bipolar Disorder, Chronic Kidney Disease, Cognitive Impairment, Bowel and Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed Anxiety, Depressed Mood, Motor Vehicle Accident, Cannabis Dependence and Alcohol Dependence. -No documentation of checks of right foot daily. Review on 03/11/26 of client #1's FL-2 dated 11/04/25 revealed: -Disoriented intermittently. -Incontinent of bladder and bowel. -Personal care assistance in bathing and dressing. -"Please supply gloves, wipes, pull up and bed pads." -Patient care-check right foot daily.	V 112	**PLAN OF CORRECTION** 1. **Immediate Corrective Actions** The Person-Centered Plan (PCP) for client #1 is being fully revised by the Qualified Professional (QP) to include: -Hygiene and incontinence care needs -Personal care assistance requirements -Mobility limitations and emergency response needs -All current client PCPs have been reviewed and updated to -ensure alignment with: -Assessments -FL-2 documentation -Medical and behavioral needs **2. Policy Revision and Implementation** **A. Person-Centered Planning Policy (REVISED)** The governing body is revising the PCP Policy to require: All PCPs must be: -Developed from the assessment -Inclusive of all identified needs (medical, behavioral, ADLs, safety) -PCP must include: -Measurable goals -Specific strategies for each identified need -Staff responsible -Review schedule **PCP Requirement:** No PCP will be considered complete unless: -All needs identified in the assessment and FL-2 are addressed -The plan is reviewed and approved by the QP **B. PCP Development Checklist** **A standardized checklist is being implemented requiring verification that PCP includes**: Hygiene and personal care needs Mobility and safety needs Medical conditions and monitoring requirements Behavioral and mental health needs Emergency response considerations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 112	Continued From page 20 Review on 02/24/26 of client #1's Person-Centered Profile (PCP) dated 10/28/25 revealed: -No strategies or goals to address client #1's incontinence and hygiene identified on the FL-2. -No strategies or goals to address client #1's ability to respond to emergencies due to wheelchair use for ambulation. Interview on 02/26/26 client #1 stated: -He resided at the facility 5 or 6 months. -He did his own hygiene. -He wanted to have independent living. Interview and on 02/24/26 staff #1 stated: -Client #1 smelled "p****y all the time, he wears a diaper and p****y he is in a wheelchair..." -Client #1 uses the bathroom "on the bed, on a pad and when he uses it on him I bathe him at his bed...I'm working with what I'm given here..." -Client #1 used a bathing pan "at his bed"...and "has a urinal," he did not use "the shower." Interview on 03/11/26 the Qualified Professional stated: -She completed the PCP for client #1. -She had not developed strategies for client #1's hygiene and incontinency and care needs. -She took responsibility for no development of any strategies or goals on client #1's PCP. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 112	C. **Clinical Review Process** All PCPs must be reviewed and signed by: Qualified Professional Consultant RN will review plans involving medical needs **3. Implementation Measures** All PCPs are now: Reviewed upon admission Updated when needs change PCP checklist is placed in each client record QP must verify completeness before implementation **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: PCPs must align with: Assessment findings FL-2 physician orders Checklist required prior to PCP approval Any missing strategies or unmet needs will result in: Immediate revision Staff retraining **MONITORING** Short-Term (First 90 Days) Weekly review of all PCPs Verification that: All needs are addressed Goals and strategies are present **Ongoing** Monthly PCP audits through QAPI Random record reviews Documentation of all audit findings maintained	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 113	Continued From page 21 (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113	**V113 – 10A NCAC 27G .0206** **Client Records** **What the Rule Requires** 10A NCAC 27G .0206 requires that: A complete client record must be maintained for each individual admitted to the facility. The record must include, at minimum: Identification information Admission and discharge dates Diagnoses Screening and assessment documentation Treatment/Person-Centered Plan Emergency contact information Signed consent for emergency medical care Documentation of services provided and progress Medical orders and related documentation (if applicable) Records must be: Accurate Complete Accessible Maintained on-site **PLAN OF CORRECTION** 1. Immediate Corrective Actions The facility is conducting a 100% ongoing audit of all current client records to ensure compliance with 10A NCAC 27G .0206. All current client records are being updated to include: Emergency contact information Signed consent for emergency medical care A standardized admission packet has been implemented to ensure all required documentation is completed at admission.	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 113	Continued From page 22 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete client records affecting 1 of 1 Former Client (FC #8). The findings are: Review on 02/27/26 of FC #8's record revealed: -Admission date of 02/03/26. -Schizophrenia Post-Traumatic Stress Disorder, Diabetes, Anxiety Disorder, Gastroesophageal Reflux Disease, Hyperlipidemia, Low B12 and Vitamin D. -Discharge date of 02/04/26. -No documentation of emergency information for FC #8. -No signed statement from FC #8's legal guardian granting permission to seek emergency care. Interview on 02/27/26 and 03/04/26 the Licensee/Registered Nurse stated: -FC #8 was admitted on 02/03/26 and discharged to a sister facility on 02/4/26. -She did not have the emergency information or consents for review at the facility for FC #8. -She took responsibility for documentation not completed for FC #8's record. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 113	2**. Policy Revision and Implementation** A. Client Records Policy (REVISED) **The governing body is revising revised the Client Records Policy to require:** A complete client record must be established at the time of admission and maintained throughout the client's stay. Required documentation includes: Emergency contact information Signed consent for emergency medical treatment All assessments, PCPs, and service documentation **Documentation Policy to be Implemented:** No client will be considered fully admitted unless: All required record components are completed and filed **B. Admission Documentation Packet** A standardized Admission Packet is being implemented requiring completion of: Face sheet with demographic information Emergency contact information Consent for emergency medical care Initial assessment and screening documentation **C. Client Record Checklist System** Each client record now includes a checklist verifying: All required documents are present Documents are signed and dated Record is complete and compliant 3. Implementation Measures Facility Director verifies completion of admission packet prior to admission Qualified Professional ensures clinical documentation is completed Client record checklist is maintained in each file **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Admission documentation requirement enforced No client admitted without completed record components Checklist must be completed and reviewed prior to admission Any missing documentation will result in: Immediate correction Staff retraining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 114	Continued From page 23 V 114 27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are: Review on 02/24/26 of client #1's record revealed: -Admission date of 10/28/25. -Diagnoses of Dementia, Left Below the Knee Amputation, Paraplegia, Schizoaffective Disorder, Bipolar Disorder, Chronic Kidney Disease, Cognitive Impairment, Bowel and Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed Anxiety, Depressed Mood, Motor Vehicle Accident, Cannabis Dependence and Alcohol Dependence.	V 114	**MONITORING** (First 90 Days) Weekly audit of 100% of client records Verification of: Emergency contact information Consent forms Required documentation **Ongoing** Monthly chart audits through QAPI Random record reviews by governing body Documentation of audit findings maintained **V114 – 10A NCAC 27G .0207 Emergency Plans and Supplies** **What the Rule Requires** 10A NCAC 27G .0207 requires that: Each facility must develop and maintain written fire and disaster plans, including: Evacuation procedures and routes Plans must: Be available to staff Be posted within the facility The facility must conduct: Fire and disaster drills at least quarterly Drills must be conducted on each shift The facility must maintain: Documentation of drills Readily accessible first aid supplies	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 114	Continued From page 24 Review on 03/04/26 of client #2's record revealed: -Date of admission: 05/02/25 -Intellectual Developmental Disability (IDD) and Schizophrenia. -FL-2 dated 11/20/25 - client was a wanderer. Review of client #3's record revealed: -Date of admission:02/22/25 -Diagnoses of IDD, Mood Disorder, Type 2 Diabetes, Urinary Incontinence and Hyperlipidemia. -FL-2 dated 11/20/25 - client was disoriented intermittently, had self-injurious behavior and was semi-ambulatory. Review on 02/25/26 of client #4's record revealed: -Date of admission: 05/20/25. -Diagnoses: Major Depressive Affective Disorder, Unspecified Intellectual Disability, Unspecified Schizophrenia Spectrum, Hypertension, Obesity, Unspecified Anxiety, Unspecified Psychosis. Review on 02/24/26 and 02/25/26 of client #5's record revealed: -Admission date of 02/03/26. -Diagnoses of Autistic Disorder, Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease (GERD), Diabetes type 2, Allergic Rhinitis and Pruritis Rash. -FL-2 dated 03/05/26 - client was intermittently disoriented, Review on 02/24/26 and 02/27/26 of client #6's record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major	V 114	**PLAN OF CORRECTION** 1. Immediate Corrective Actions Fire and disaster plans are being; Reviewed Updated Posted in visible areas throughout the facility A current fire drill and disaster drill schedule is being established A fire drill has been conducted to initiate compliance First aid kits have been verified to be complete, accessible, and properly stocked 2. Policy Revision and Implementation A. Emergency Preparedness Policy (REVISED)) The governing body is revising the Emergency Preparedness Policy to require: -Fire and disaster plans must: -Be maintained on-site -Be posted in common areas -Be reviewed with staff upon hire and annually -Fire and disaster drills must: -Be conducted at least quarterly -Be conducted on all shifts -Simulate realistic emergency conditions **B. Drill Documentation System** **A standardized Emergency Drill Log is being implemented requiring documentation of:** -Date and time of drill -Type of drill (fire/disaster) -Staff and clients participating -Evacuation time -Identified issues and corrective actions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 114	Continued From page 25 Depressive Disorder, Anxiety, Aphasia and Dysphasia. Review on 02/25/26 of facility records from April 2025 thru December 2025 revealed: -No documentation of 2nd quarter disaster drills (April , May and June). -No documentation of 3rd quarter disaster drills (July, August and September). Review on 03/12/26 of the DHSR (Division of Health Service Regulation) Construction Section survey dated 03/10/26 revealed: -"1. At the time of the survey, a surprise fire drill was performed. There were five clients present in the home at the time of the fire drill. None of the five clients responded or evacuated the home at the time the alarms were activated. This home was licensed as a home for all ambulatory clients. Based on the rule, an ambulatory client must be able to respond and evacuate at anytime the alarms are activated, without staff prompting or assistance. The clients need to be trained to respond and evacuate without staff prompting or assistance at anytime the alarms are activated. If the clients are unable to perform this, they may need to be relocated to another home that is more suited for their needs. The home can also be remodled to accommodate non-ambulatory clients. This would require a project to be submitted to DHSR construction and the addition of sprinklers and fire alarms per Section 428.4 of the 2018 North Carolina State Building Code. Take the necessary steps to bring the home into compliance by implementing one of the above scenarios." Interview on 02/24/26 client #1 stated: -The facility did fire and disaster drills. -The facility conducted drills monthly.	V 114	**C. Emergency Plan Accessibility** **Emergency plans are:** -Posted in key locations (hallways, common areas) -Included in staff orientation materials -Staff must demonstrate knowledge of: -Evacuation routes -Emergency procedures 3**. Implementation Measures** -Facility Director schedules all drills in advance -Staff are assigned roles during drills -Drill results are reviewed and discussed with staff **PREVENTION OF RECURRENCE** **To ensure this deficiency does not recur:** -Quarterly drill schedule maintained and enforced -Drill completion required for all shifts -Documentation must be completed immediately following each drill -Any missed or incomplete drill will result in: -Immediate rescheduling -Administrative review **MONITORING** (First 90 Days) Monthly review of drill documentation Verification that drills are completed as scheduled **Ongoing** Quarterly review through QAPI Random review of drill logs by governing body Documentation maintained for survey review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 114	Continued From page 26 Interview on 02/24/26 and 02/27/26 staff #1 stated: -He had worked at the facility for over a month. -For client #1 who can get out of the facility, he would pick him up out of his wheelchair in the event of a fire and carry him out of the facility. -He would have client #6 who utilizes a rollator to ambulate, "have him hold on to me and guide him out." -For client #6, "direct him, show him to the window or get him to the door assist him him to the window, just get the window up first leg out and second let out and go to the road, tell him go to the road." -Client #2, "...direct him, show him to a window or get him to a door, or assist him to a window, just get the window up, first leg out and second leg out say go to the road tell him go." -"[Client #3] same as [client #2], [client #3] knows go out window if a fire." -"[Client #5] he would have to hold on to me, he can walk...would have to have me guide him out and [client #4] guide him too. Put one foot out open window was far as him and his condition I would have to tell him to go but he pauses when he walks don't know if he would get to the street, he pauses when he walks, don't know why, he slow walks like that, maybe counting his steps..." -He worked 2 weeks on a 2 weeks off. -There was one shift at the facility. -The Licensee/Registered Nurse (RN) did the drills. Interview on 03/11/26 the Division of Health Service Regulation (DHSR) surveyor with the construction section stated: -He utilized the fire alarm on 3/10/26 to determine how the clients would react and evacuate out of	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 114	Continued From page 27 the facility under a drill simulation. -When the fire drill was conducted no client evacuated from the facility in response to the fire drill. -Client #1 could maneuver in his wheelchair however, he did not make an effort to evacuate out of the facility. Interview on 03/11/26 the Qualified Professional stated: -"I can't speak to [client #5] may need verbal assistance, everyone else should be able to get out the door when we say fire, hit the door, go to mailbox; [client #1] may need assistance but he knows what to do. Don't know [client #5], he would need verbal assistance to get out. -They all should have exited and they all would have known to go out (during fire drill conducted by DHSR on 3/10/26)...[client #2] didn't exit because of being on the phone..." Interview on 03/44/26 the Licensee/Registered Nurse stated: -"Within 5 minutes staff (staff #1) would call them and they could all get out and he (client #1) could slide out and get in his wheelchair and get out; staff tell them, get out and they get out, it's the staff not doing his job..."	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased	V 117	**V117 – 10A NCAC 27G .0208** **Infection Control and Prevention** **What the Rule Requires** 10A NCAC 27G .0208 requires that: The facility must develop and implement policies and procedures to prevent, control, and investigate infections and communicable diseases among clients and staff. The facility must ensure: Proper infection control practices are followed Staff are trained in infection prevention and bloodborne pathogens Appropriate use of personal protective equipment (PPE) Proper sanitation and hygiene practices The governing body must ensure: Ongoing monitoring of infection control practices	04/03/2026

			Implementation of procedures to protect client health and safety	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4	24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 117	Continued From page 28 or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure all prescription drugs had a packing label with required information affecting 1 of 3 audited clients (#6). The findings are: Review on 02/24/26 and 02/27/26 of client #6's record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major Depressive Disorder, Anxiety, Aspasia and Dysphasia. -Physician order dated 11/05/25 for Symbicort	V 117	**PLAN OF CORRECTION** 1. **Immediate Corrective Actions** -The facility conducted an immediate review of infection control practices. -All staff are being provided initial infection control training, including: -Hand hygiene -Use of PPE -Bloodborne pathogen precautions -The facility has ensured availability of: Gloves, masks, and other PPE Cleaning and sanitation supplies **2. Policy Revision and Implementation** A. Infection Control Policy (REVISED) The governing body is revising and implemented an Infection Control Policy requiring: -Standard precautions for all client care -Proper hand hygiene before and after all client contact -Use of PPE when exposure to bodily fluids is possible -Proper cleaning and disinfection of surfaces and equipment -Procedures for identifying and responding to communicable diseases **B. Infection Control Program** A structured Infection Control Program is being implemented, including: -Routine sanitation schedules -Monitoring of infection control practices -Documentation of any communicable disease	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	**2409 BEL AIR AVENUE SE WILSON, NC 27893**

(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
V 117	Continued From page 29 (Breyna) (asthma) 80 micrograms inhaler - inhale 2 puffs twice daily. Observation on 02/24/26 at approximately 3:00pm of Client #6's medications revealed: -No pharmacy label on Breyna to include the client's name, the prescriber's name, the current dispensing date, clear directions for self-administration, the name, strength, quantity and expiration date of the prescribed drug, and the name, address, and phone number of the pharmacy or dispensing location and the name of the dispensing practitioner. Interview on 02/24/26 and 02/25/26 the Licensee/Registered Nurse stated: -"That's the way it (Breyna) came (no label)." This deficiency is cross referenced into 10A NCAC 27G .0209 (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 117	And incidents -Procedures for reporting and managing infections **C. Staff Training Requirement** All staff must complete infection control training: Upon hire Annually thereafter Training must include: -Bloodborne pathogens -PPE use -Hygiene and sanitation procedures 3. **Implementation Measures** Infection control supplies are maintained and readily accessible Cleaning schedules are posted and followed Staff adherence to infection control practices is monitored daily **PREVENTION OF RECURRENCE** **To ensure this deficiency does not recur:** Infection control practices are required at all times Staff must demonstrate competency prior to working independently Any failure to follow infection control procedures will result in: Immediate corrective action Retraining **MONITORING** (First 90 Days) Weekly monitoring of infection control practices Review of staff compliance with PPE and hygiene procedures **Ongoing** Monthly infection control audits through QAPI Documentation of findings and corrective actions Random observation of staff practices	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 30 (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed 1) to ensure 2 of 4 audited staff (#1 and Licensee/Registered Nurse (RN)) demonstrated competency in medication administration for 1 of 3 audited clients (#6) and 2) to administer medications on the written order of a physician and ensure the MARs were kept current affecting 2 of 3 audited clients (#1 and #3). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V117). Based on record review, interview, and observation, the facility failed to ensure all prescription drugs contained a packing label with the required information affecting 1 of 3 audited clients (#6).	V 118	**V118 – 10A NCAC 27G .0209 Medication Requirements** **What the Rule Requires** 10A NCAC 27G .0209 requires that: Medications must be administered safely and in accordance with physician orders. The facility must ensure: Proper medication administration procedures Accurate and complete Medication Administration Records (MARs) Medications are stored, labeled, and secured properly Staff administering medications are trained and competent The facility must ensure: Monitoring of medication effects and side effects Documentation of medication administration Any clinical testing related to medication (e.g., blood glucose monitoring) must comply with applicable standards, including CLIA requirements when applicable **PLAN OF CORRECTION** 1. Immediate Corrective Actions The facility has applied for a CLIA waiver to ensure compliance with federal requirements for point-of-care testing. Pending CLIA approval: Blood glucose monitoring is: Conducted only by appropriately licensed personnel, OR	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 31 Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120). Based on record reviews, observation and interviews, the facility failed to ensure that external medication were stored separately from internal medications and failed to ensure medications were kept in a locked container when stored with refrigerated foods affecting 2 of 3 audited clients (#5 and #6). Finding #1: Review on 02/24/26 and 02/27/26 of client #6 record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness , Major Depressive Disorder, Anxiety, Aphasia and Dysphasia. Review on 02/27/26 of client #6's physician orders dated 11/05/25 revealed: -Humalog (insulin) 6 units - 4 times a day with meals and hold for a blood sugar value less than 110. -Notify provider for finger stick blood sugar (FSBS) less than 70 or greater than 400. Review on 02/24/26 of a handwritten document from 02/03/26 thru 02/17/26 labeled with client #6's name revealed the following dates, times and FSBS values -02/03/26 - 7am - 90, 12 noon - 84, 5pm - 90 and 8pm - 86. -02/04/26 - 7am - 89, 12 noon - 80, 5pm - 90 and 8pm - 96. -02/05/26 - 7am - 96, 12 noon - 80, 5pm - 86 and 8pm - 88. -02/06/26 - 7am - 88, 12 noon - 90, 5pm - 84 and 8pm - 90. -02/07/26 - 7am - 87, 12 noon - 90, 5pm - 92 and	V 118	Referred to an external licensed provider All physician orders related to medications and monitoring have been reviewed and verified for accuracy. Medication Administration Records (MARs) have been reviewed and updated. **2. Policy Revision and Implementation** A. Medication Administration Policy (REVISED) The governing body is revising the Medication Policy to require: -Medications must be administered: -Exactly as prescribed -By trained and authorized staff **All administrations must be:** -Documented immediately on the MAR Medications must be: Properly labeled Stored securely **B. Clinical Testing / CLIA Compliance Policy** A new policy is being implemented requiring: **No point-of-care testing (including blood glucose monitoring or urine drug screens) will be conducted unless:** The facility has an active CLIA waiver, AND Staff are trained and competency validated If CLIA waiver is not active: Testing must be performed by: Licensed medical personnel, or External certified laboratories	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 32 8pm - 90. -02/08/26 - 7am - 99, 12 noon - 92, 5pm - 90 and 8pm - 90. -02/09/26 - 7am - 102, 12 noon - 92, 5pm - 92 and 8pm - 90. -02/10/26 - 7am - 102, 12 noon - 94, 5pm - 97 and 8pm - 92. -02/11/26 - 7am - 87, 12 noon - 94, 5pm - 98 and 8pm - 101. -02/12/26 - 7am - 90, 12 noon - "F" (at day program per staff #1), 5pm - 86 and 8pm - 90. -02/13/26 - 7am - 89, 12 noon - "F", 5pm - 103 and 8pm - 98. -02/14/26 - 7am - 147, 12 noon - "F", 5pm - 94 and 8pm - 99. -02/15/26 - 7am - 98, 12 noon - 84, 5pm - 97 and 8pm - 80. -02/16/26 - 7am - 87, 12 noon - "F", 5pm - 94 and 8pm - 90. -02/17/26 - 7am - 92, 12 noon - "F", 5pm - 104 and 8pm - 90. -The average FSBS for client #6's FSBS values for 02/03/26 thru 02/17/26 was 92.5. Review on 02/26/26 of a glucometer labeled with client #6's name revealed the following dates and times of FSBS results for the past 30 days revealed: -02/10/26 at 11:31am - "HI" (per manufacture "HI" means not able to read results). -02/14/26 at 8:22am - 378. -02/14/26 at 8:25am - 354. -No other FSBS results registered on the glucometer. Review on 02/24/26 of a January 2026 MAR from client #6's previous adult care facility's admission revealed the following dates, times and FSBS values: -Insulin Lispro (Humalog) - inject 6 units 4 times	V 118	C. **Medication Oversight System** Daily review of MARs by supervisory staff Verification of: Correct medication Correct dosage Correct timing Monitoring of client response to medications 3**. Implementation Measures** Medication carts and storage areas have been secured and organized MAR documentation procedures standardized All staff administering medications have been verified as trained and competent **PREVENTION OF RECURRENCE** **To ensure this deficiency does not recur:** -No clinical testing without CLIA compliance -Staff must be trained and competency validated prior to administering medications -All medication-related activities must be documented -Any deviation from policy will result in: -Immediate corrective action -Staff retraining **MONITORING** (First 90 Days) Daily review of MARs Weekly medication audits Verification of compliance with physician orders and testing requirements **Ongoing** Monthly medication audits through QAPI Random checks of medication storage and documentation CLIA compliance verification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 33 daily with meals. Hold for FSBS less than 110. -FSBS documented results for the following dates, times and blood sugar values. -01/01/26 - 8am - 176, 12pm - 214, 5pm - 69 and 8pm - no documentation. -01/02/26 - 8am - 153, 12pm - 118, 5pm - 62 and 8pm - no documentation. -01/03/26 - 8am - 149, 12pm - 131, 5pm - 196 and 8pm - 227. -01/04/26 - 8am - 169, 12pm - 159, 5pm - 87 and 8pm - 102. -01/05/26 - 8am - 131, 12pm - 202, 5pm - 235 and 8pm - no documentation. -01/06/26 - 8am - 189, 12pm - 320, 5pm - 466 and 8pm - 80. -01/07/26 - 8am - 121, 12pm - 250, 5pm - 424 and 8pm - 397. -01/08/26 - 8am - 240, 12pm - 88, 5pm - 63 and 8pm - no documentation. -01/09/26 - 8am - 156, 12pm - 124, 5pm - 260 and 8pm - . no documentation -01/10/26 - 8am - 178, 12pm - 214, 5pm - 131 and 8pm - 154. -01/11/26 - 8am - 103, 12pm - 223, 5pm - 180 and 8pm - 293. -01/12/26 - 8am - 183, 12pm - 235, 5pm - 183 and 8pm - 259. -01/13/26 - 8am - 284, 12pm - 192, 5pm - 177 and 8pm - no documentation. -01/14/26 - 8am - 200, 12pm - no documentation, 5pm - no documentation and 8pm - no documentation. -01/15/26 - 8am - 145, 12pm - 35, 5pm - 105 and 8pm - no documentation. -01/16/26 - 8am - 85, 12pm - 127, 5pm -322 and 8pm - no documentation. -01/17/26 - 8am - 64, 12pm - 144, 5pm - 205 and 8pm - 204. -01/18/26 - 8am - 174 12pm - 243, 5pm - 191 and 8pm - 261.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 34 -01/19/26 - 8am - 134, 12pm - 300, 5pm - 256 and 8pm - no documentation. -01/20/26 - 8am - 164, 12pm - 223, 5pm - 91 and 8pm - 192. -01/21/26 - 8am - 127, 12pm - 135, 5pm - 297 and 8pm - no documentation. -01/22/26 - 8am - 66, 12pm - no documentation, 5pm - 137 and 8pm - 189. -01/23/26 - 8am - 60, 12pm - no documentation, 5pm - 294 and 8pm - 99. -01/24/26 - 8am - 105, 12pm - 157, 5pm - 93 and 8pm - 109. -01/25/26 - 8am - 160 12pm - 160, 5pm - no documentation and 8pm - no documentation. -01/26/26 - no documentation. -01/27/26 - no documentation. -01/28/26 - 8am - no documentation, 12pm - no documentation, 5pm - 255 and 8pm - no documentation. -01/29/26 - 8am - 129, 12pm - no documentation, 5pm - no documentation and 8pm - no documentation. -01/30/26 - no documentation. -01/31/26 - no documentation. -Average documented FSBS value for January 2026 was 178.6. Review on 02/25/26 of the current facility's February 2026 MAR for client #6 which was lost from the facility and located at the local hospital revealed: -Insulin Lispro inject 6 units - 4 times a day with meals for Diabetes. Hold for FSBS less than 110. Notify provider for FSBS less than 70 or greater than 400. -Times for medications 8am, 12pm, 5pm and 8pm. -Staff #1's initials to indicate the insulin was administered 4 times daily from 02/03/26 thru 02/11/26, 02/14/26, 02/15/26 and 02/16/26 thru	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 35 02/21/26. -Staff #1's initials to indicate the insulin was administered 3 times a daily on 02/12/26, 02/13/26 and 02/16/26 thru 02/18/26. -The letter "F" documented in the 12pm section for 02/12/26, 02/13/26 and 02/16/26 thru 02/18/26. -Per physician orders dated 11/05/25, the only dose of insulin as a result of a FSBS value would have been 02/14/26 - 7am - 147. -The reverse side of the MAR revealed 02/07/26 - insulin not given FSBS - 87, 02/08/26 insulin not given FSBS - 99, 02/09/26 insulin not given FSBS - 103, 02/10/26 "ate before I tell him" "high" (had 2 lines thru it) FSBS102 -02/12/26, 02/09/26, 02/10/26 and 02/06/26 no insulin given "went to program." Review on 02/26/26 of the local county 911 emergency system recording dated 02/22/26 revealed: -7:02am. -The Former Staff (FS #5) caller identified themselves as a staff at the facility. -The caller stated a client had fallen for an undetermined amount of time. -Former Staff #5 could be heard asking client #6 "what is your name?" And client #6 replied "[client #6]." Review on 02/26/26 of a "communication" from the Emergency Medical Services (EMS) revealed: -Date - 02/22/26. -EMS was dispatched to the facility address at 7:02am for a reported fall. Review on 02/26/26 of an EMS report dated 02/22/26 revealed: -7:16am Assessment -Chief Complaint: Fall	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 36 -Secondary Complaint: Possible Sepsis -Glucose (sugar) 377. -"History of Present Illness Medic 3 was dispatched to a 68 y/o (year old) in reference to a fall ...the pt. (patient) stated he did not remember falling but did fall the night before and was on the floor all throughout the night. The pt. did throw up twice prior to EMS. The pt. stated he had been feeling sick the last few days and has been having issues with his BS (blood sugar). A C-collar was placed. The pt. was assisted off the floor and placed on the stretcher. The pt. was placed on the monitor. The pt. was noted to hyperglycemic. The pt. was slightly lethargic but was alert. The pt. was placed in the ambulance. Axillary temperature was 94.0 F (Fahrenheit). Due to vitals, the pt. was noted to be a cold sepsis activation. IV access was obtained, The pt. was given warm fluids. Heat packs were placed underneath the pt's arms ..." Review on 02/26/26 of client #6's medical record from a local hospital admission on 02/22/26 revealed: -"Initial Time seen by provider: 8:17 (am) External Historian: EMS History of present illness This is a 68-year-old male with a history of diabetes who presents to the emergency room via EMS from his group home for a fall. Per EMS group home states that patient has been on for proximally 1 hour, patient states that he has been on the floor for most of the night. EMS placed patient was C-collar prior to arrival for precautions." -Emergency Department Report - "pt (patient) arrives via ems from group home for an unwitnessed fall. Facility says pt was on ground no longer than 20 mins (minutes), but pt endores being on the ground all night. Pt had 2 vomiting episodes prior to ems arrival. EMS vitals : 94.0 temp (temperature).	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 37 -"Given the severity of acidosis, need for continuous insulin infusion, and concern for possible sepsis and prolonged downtime, the patient required admission to a high level of care for continued management, serial laboratory monitoring, and further evaluation ...Due to a high probability of clinically significant, life threatening deterioration, the patient required my highest level of preparedness to intervene emergently and I personally spent this critical care time directly and personally managing the patient. This critical care time included obtaining history; examining the patient; pulse oximetry; ordering and review of studies; arranging urgent treatment with development of a management plan; evaluation of patient's response to treatment; frequent assessment; and , discussions with other providers. This critical care time was performed to assess and manage the high probability of imminent, life-threatening deterioration that could result in multi-organ failure ...Disposition Type: Hospitalize Condition: Critical." -"Additional Comments Medical Decision Making: This is a 68-year-old male who presented to the emergency department via EMS from his group home after a reported ground-level fall. Per EMS, staff reported the patient had been down for most of the night. A cervical collar was applied prior to arrival due to the mechanism of injury. On arrival, the patient was tachycardia, prompting initiation of a sepsis alert. Given the unclear downtime and abnormal vital signs, a broad workup was initiated including trauma evaluation, infectious workup, and metabolic studies ...Overall findings were consistent with severe diabetic ketoacidosis (a life-threatening, emergency complication of diabetes caused by high blood sugar and insufficient insulin) (DKA), with concern for	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 38 possible concurrent sepsis (infection) given leukocytosis (increase white blood cells), lactic acidosis (build up of lactic acid in blood), and tachycardia ...An insulin drip was initiated per DKA protocol with close monitoring of glucose and electrolytes." -"Hx (history) of present illness Mr. [client #6] is a 68 year old male presenting to the hospital for fall ...Patient was found on the floor of his group home with unclear amount of time. Patient himself said he was there for some time however the group home says that he was there for about an hour. He has been treated with sepsis fluids due to mild hypothermia and tachycardia. He was found to be DKA with metabolic acidosis 7.1 ...Assessment/Plan DKA with uncontrolled type 2 diabetes Hyperglycemia -admit to inpatient medicine ..." -02/22/26 - A1C (measures average blood sugar of 2 or 3 months) at 8:15am - 9.1% (0 to 5.9% within normal limits). -02/22/26 - Bedside glucose 8:09am - 483 (normal range 65-110), 8:15am - 419, 2:53pm - 359, 3:50pm - 218, 3:52 - 200, 4:21pm - 201and 5:11pm - 189. -02/22/26 X-Ray right knee - Small joint effusion (inflammation, injury or infection). Interview on 02/25/26 with client #6 at the local hospital Intensive Care Unit (ICU) revealed: -"...had diabetes all my life, 130 is good, don't remember them (staff) checking it (blood sugar value) at the group home -Started having problems, started throwing up on Sunday (02/22/26) -I couldn't get off the floor by myself, didn't get checked on. Sunday (02/22/26) - Can walk with a walker -Sugar over 400 in ICU -"...bruise on knee, might have slid on the floor,	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 39 couple of hours, might have been dark, the EMT (Emergency Management Technician) picked me up off the floor and helped get me off the floor and put a neck brace on me." -"I wear pull-ups." -I can shower by myself, I use a certain shower in a bedroom in another client's room, he's laying down on their bed. -Meals, not eating right, basically pizza and what was in front of me, spaghetti, corn dogs, bologna sandwiches... -I had a stroke left eye, loss vision -"It should be against the law for them to do me the way they did me." Interview on 02/25/26 client #6's sister/legal guardian stated: -"Most of the visits to the group home he (client #6) was not clean, could smell the urine on him. His clothes not clean, been there (group home) two times." -"I heard the next day, [Licensee/RN] called me 9 on Sunday morning, she said I don't need to come,...[Licensee/RN] said to the front desk people that he (client #6) didn't need a neck brace, that he didn't fall and you must have him confused with somebody else." -"His pants smelled so bad with urine smell; I took took [client #6]'s pants home to wash them and washed them several times and still couldn't get the urine stink out." - No pull ups in his size. "I took him some out of my car, he has accidents bowel poops, out of no where...she [Licensee/RN] said he has BMs (bowel movements) on himself." Interview on 03/03/26 the Case Manager from the local hospital stated: -She was a RN. -An A1C is an approximately 3 month review of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 40 diabetic blood sugars. -An A1C of 9.1 would not be a well controlled diabetic and indicative of client #6's documented February 02/03/26 thru 02/17/26 blood sugar values. -She would contact the admitting care provider for client #6 on 02/22/26 to provide additional information on an A1C of 9.1 Finding #2: Review on 02/24/26 of client #1's record revealed: -Admission date of 10/28/25. -Diagnoses of Dementia, Left Below the Knee Amputation, Paraplegia, Schizoaffective Disorder, Bipolar Disorder, Chronic Kidney Disease, Cognitive Impairment, Bowel and Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed Anxiety, Depressed Mood, Motor Vehicle Accident, Cannabis Dependence and Alcohol Dependence. Review on 02/24/26 and 02/25/26 of client #1's physician orders dated 11/20/25 revealed: -Baclofen (muscle relaxant) - three times a day. Review on 03/11/26 of client #1's February 2026 MAR revealed: -Baclofen three times a day at 8am, 2pm and 8pm. -"F" written in the following 2pm medication times: 02/02 thru 02/07, 02/09 thru 02/14, 02/16 thru 02/18, 02/23 and 02/24. -No staff initials to indicate Baclofen 2pm was administered as ordered on 02/02 thru 02/07, 02/09 thru 02/14, 02/16 thru 02/18, 02/23 and 02/24. Review on 02/25/26 of client #1's medications revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 41 -Baclofen was in a separate perforated daily pill bubble pack with 2pm printed on the seal. Interview on 02/26/26 client #1 stated: -He resided at the facility 5 or 6 months. -He was not able to recall the names of his medications. -He knew he received his medications daily. Finding #3: Review on 02/25/26 of the Licensee/RN's record revealed: -Date of hire: 12/12/24. Review and interview on 02/27/26 of a previously reported lost February 2026 MAR for client #6 presented by the Licensee/RN as an original document revealed: -There was no indication on the document it was created for a demonstration, an example or recreated for educational purposes. -When interviewed regarding the authenticity of the MAR, the Licensee/RN stated she had created the MAR as an example of the lost MAR for client #6. -She wrote staff #1's initials on the MAR to indicate medications were administered from 02/03/26 thru 02/21/26. -She just completed the document as an example regarding the previously reported lost MAR for client #6 presented by the Licensee/RN as an original document on 02/27/26, "I'm sorry, I'm not using it." (the created MAR from above)." -The created MAR was "just a sample." -Below are the medications and dates the Licensee/RN used staff #1's initials to indicate the medication was administered. -Sertraline (antidepressant) 100 milligrams (mg) at 8am - 02/03/26 thru 02/21/26. -Metoprolol (HTN) 50mg daily - 02/03/26 thru	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 42 02/21/26. -Lantus (insulin) inject 35units at bedtime - 02/03/26 thru 02/21/26. -Humalog 10 units 3 times daily with meals - 02/10/26 at 8am, 02/11/26 at 7pm, 02/13/26 at 7pm, 02/14/26 at 8am, 02/17/26 at 7pm, 02/20/26 at 7pm and 02/21/26 at 7am, 2pm and 7pm. -Olopatadine (eye allergy) instill in both eyes twice daily - 02/03/26 thru 02/21/26. -Vit B-12 (Vitamin Deficiency) dissolve under tongue daily - 02/03/26 thru 02/21/26. -Aspirin (heart) 325mg once daily - 02/03/26 thru 02/21/26. -Acetaminophen (pain relief) 325mg twice daily - 02/03/26 thru 02/21/26. -Atorvastatin (cholesterol) 40mg once daily - 02/03/26 thru 02/21/26. -Breyna (asthma) inhale 2 puffs twice daily - 02/03/26 thru 02/21/26. -Certavite (vitamin) take one tablet daily - 02/03/26 thru 02/21/26. -Cetirizine (allergies) 10mg take daily - 02/03/26 thru 02/21/26. -Metformin (diabetes) 1,000mg take twice daily - 02/03/26 thru 02/21/26. -Glycopyrrlate 1mg take twice daily - 02/03/26 thru 02/21/26. -Levothyroxine (thyroid) 175 micrograms take once daily - 02/03/26 thru 02/21/26. -Vitamin (vitamin d deficiency) D3 1000 units take daily - 02/03/26 thru 02/21/26. Interview on 02/24/26, 02/27/26 and 03/04/26 staff #1 stated: -The previously reported lost MAR for client #6 presented by the Licensee/RN as an original document on 02/27/26 was not initialed by him. -The "F" on the blood sugar sheet indicated client #6 was at the day program. -Client #6 went to the day program 5 days.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 43 -He had worked at the facility for about a month. -Client #6 was not acting right on 2/22/26. -He called 911 on 02/22/26. -EMS took client #6 to the hospital. -Checked client #6 FSBS 4 times daily. -Client #6 started to act different on Friday, 02/20/26, such as staring. -Client #6 went to the day program 5 days. Interview on 02/26/26 the Director of the Day Program/PSR stated: -The program does not give medications to any clients. -The policy says this and that she does not have the staff to give the medications. Interview on 02/24/26, 02/27/26 and 03/04/26 the Licensee/Registered Nurse stated: -She was not responsible for client #6's care when he was away from the facility. -She was not responsible for client #6's medications if he was out of the facility at the day program. -She had not coordinated with the day program regarding client #6's blood sugar checks or potential need of insulin injections. -Client #1 went to the day program Monday thru Friday and returned back to the group home at various hours after approximately 3:30 - 5:45 pm. -She had not coordinated with the day program regarding client #1's 2pm dose of Baclofen. -Client #1 is given his 2pm Baclofen after he returned home from the day program, 4pm to 5:30 depending on the traffic. -She was going to discuss client #1's Baclofen times with the primary care provider. -Client #6 did not fall at the facility. -Client #6's FSBS was checked by staff #1. -EMS had taken the February 2026 MAR for client #6 when transported to the hospital.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 44 Interview on 03/11/26 the Qualified Professional stated: -Client #1 can take the Baclofen at 8am in the morning and at 11pm before he goes to bed. -She did not think it was a "good idea" to accept client #1 into the facility until he showed he could take care of himself. -"That should not have happened." "It makes no sense" and "I don't have an answer for that" when referring to the lost MAR for client #6 presented by the Licensee/RN as the original document on 02/27/26. Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 03/04/26 of the Plan of Protection (POP) dated 03/04/26 written by the Licensee/RN revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection Immediate Protections Admin (administrator/Licensee/RN) 1. Provide [plastic bags] for storage of ointment separately with other medications. 2. Provide a locked box for insulin storage 3. Inform provider about client out of facility during the day for proper medication dosage adjustment 4. Checking all medications on admission to make sure all medications are available for administration upon admission. -Describe your plans to make sure the above happens. B Plans to make sure the above happens 1. Training staff on proper medication storage - ointments in [plastic bags] separate from other medications and insulin in a locked box. 2. Training staff on reporting any medication	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 45 that was not administered 3. Checking all medication on admission to make sure all medications are available for administration upon admission." -Amended POP dated 03/04/26 written by the Licensee/RN revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection -Administrator will ascertain that all medications are properly stored, labeled, administered by the staff to the clients as ordered by the providers at their right time. -Describe your plans to make sure the above happens. Plans Administrator will - Train staff on proper storage and labeling of medications - Train staff to properly administer medication as ordered by the provider. - Checking medication form weekly to ensure plan is enforced." Clients #6 and client #1 with diagnoses of Diabetes, Muscle Weakness, Major Depressive Disorder, Anxiety, Aphasia and Dysphasia, Dementia, Left Below the Knee Amputation, Paraplegia, Schizoaffective Disorder, Bipolar Disorder, Chronic Kidney Disease, Cognitive Impairment, Bowel and Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed Anxiety, Depressed Mood, Motor Vehicle Accident, Cannabis Dependence and Alcohol Dependence. Client #6 was a 68 year old male admitted to the facility on 02/03/26 from a local assisted living facility. He was prescribed Lantus at bedtime and Humalog six units 4 times a day if his FSBS was greater than 110. Staff initials indicated the Humalog was administered 4 times a day for a total of 80 doses in February 2026. According to the documented FSBS values for February 2026 client #6 would have received 1	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 46	V 118		

dose of Humalog on 02/14/26 at 7am. FSBS values at the facility during 02/03/26 thru 02/17/26 averaged 92.5. In contrast, client #6's FSBS was at an average of 178.6 during January 2026. This was 78 points difference from January 2026 thru February 2026. Client #6's personal glucometer had a total of 3 readings during his admission. Client #6 began to experience symptoms noticed by staff #1 on 02/20/26. On 02/22/26 EMS was contacted by FS #5 the facility due client #6's fall. It was reported by staff repeatedly no fall had occurred at the facility. Client #6 reported he was on the floor of the facility for an undetermined amount of time. EMS staff reported client #6 was on the floor and was diagnosed with mild hypothermia and a FSBS value of 377. Client #6 was taken to the emergency department and was admitted to the intensive care unit. Client #6's condition was noted to be critical and potential for multi-organ failure. Client #6's A1C was 9.1. The documented FSBS at the facility was not consistent with the January 2026 FSBS values or the labs documented at the hospital upon arrival. Client #1 was medically ordered to have Baclofen 3 times daily including one dose at 2pm. Client #1 attended the day program Monday thru Friday and did not return to the facility until after 3pm. No documented staff initials to indicate client #1's Baclofen was administered as ordered for a total of 17 doses in February 2026. The staff kept external and internal medications together as well as the client #6's unlocked Humalog in a staff refrigerator which contained food items. The Licensee/RN created a MAR for client #6 and presented it as the original document. Client #6's FSBS and inconsistent documentation, the inability to document medications administered and the competency of the staff #1 and the Licensee/RN constituted an A1 for serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 118	Continued From page 47 neglect.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure that external medications were stored separately from internal medications and failed to ensure medications were kept in a locked container when stored with refrigerated foods affecting 2 of 3 audited clients (#5 and #6). The findings are:	V 120	**V120 – 10A NCAC 27G .0303** **Facility Safety and Client Protection** **What the Rule Requires** 10A NCAC 27G .0303 requires that: The facility must ensure a safe, secure, and humane environment for all clients. The facility must: Protect clients from harm, abuse, neglect, or exploitation Ensure supervision appropriate to client needs Maintain an environment that supports client health, safety, and well-being The governing body must ensure: Systems are in place to identify and address risks Staff are trained to respond to client needs and safety concerns **PLAN OF CORRECTION** 1. Immediate Corrective Actions All clients are being assessed to identify: -Health and safety risks -Supervision needs -Hygiene and personal care needs -Immediate interventions have been implemented to ensure -Clients receive appropriate personal care -Health and safety risks are addressed -Person-Centered Plans (PCPs) have been updated to reflect identified risks and required interventions:	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 120	Continued From page 48 Finding #1: Review on 02/24/26 and 02/27/26 of client #6 record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major Depressive Disorder, Anxiety, Aphasia and Dysphasia. Review on 02/27/26 of client #6's physician orders dated 11/05/25 revealed: -Humalog (insulin) 6 units - take 4 times daily with meals. Hold for finger stick blood sugar value less than 110. Observation on 02/27/26 at approximately 11:30am of the refrigerator in the staff quarters revealed: -A small dorm sized refrigerator. -An unlocked padded envelope which contained client #6's Humalog pens. -Several packages of luncheon meat and a jar of cheese dip. Finding #2: Review on 02/24/26 and 02/25/26 of client #5's record revealed: -Admission date of 02/03/26. -Diagnoses of Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease, Diabetes type 2, Allergic Rhinitis and Pruritis Rash. Review on 02/24/26 and 02/25/26 of client #5's physician orders dated 07/21/25 revealed: -Vitamin B complex (supplement) - oral -Iron 325 milligrams (mg) -Metformin (diabetes) 500mg -Vitamin D3 2000 units. -Hydrocortisone (anti-itch) cream 2.5% apply twice daily	V 120	2. **Policy Revision and Implementation** **A. Client Safety and Supervision Policy (REVISED)** The governing body is revising the Safety Policy to require: **Each client must have:** -An individualized level of supervision based on assessed needs Staff must: -Provide assistance with hygiene and personal care as needed -Monitor clients for safety risks (mobility, medical, behavioral) All risks must be: -Documented -Addressed through the PCP **B. Risk Assessment and Monitoring System** A structured Client Risk Assessment Tool is being implemented to identify: -Fall risk -Hygiene needs -Mobility limitations -Medical conditions -Risk assessments are: -Completed at admission Updated as needed **C. Incident and Safety Reporting System** All safety concerns must be: Documented Reported immediately to supervisory staff Corrective actions must be implemented and documented 3. **Implementation Measures** Staff provide daily monitoring of client safety and care needs Supervisory staff review client care daily Safety concerns are addressed immediately **PREVENTION OF RECURRENCE** **To ensure this deficiency does not recur:** All client needs must be: Identified through assessment Addressed in the PCP Staff must follow individualized care plans Any unmet need or safety concern will result in: Immediate intervention Staff retraining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 120	Continued From page 49 Observations on 02/25/26 and 02/27/26 of client #5's medications revealed: -02/25/26 at approximately 12:30pm client #5's Hydrocortisone was stored with his internal medications. -02/27/26 at approximately 11:00am client #5's Hydrocortisone was stored with his internal medications. Interview on 02/27/26 staff #1 stated he had his food items in the staff quarters' refrigerator with client #6's medications. Interview on 02/27/26 the Licensee/Registered Nurse stated: -Client #5's Hydrocortisone was normally stored in a separate plastic bag. -She would ensure external and internal medications were kept separate. -Client #6's medications were kept in the small refrigerator in the staff quarters. -She would get a locked box for refrigerated medications. This deficiency is cross referenced into 10A NCAC 27G .0209 (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 120	**MONITORING** (First 90 Days) Weekly review of client care and safety needs Verification that: PCPs address all identified risks Staff are following care plans Ongoing Monthly safety audits through QAPI Review of incident reports Random observation of staff care practices	
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131	**V131 – G.S. 131E-256** **Health Care Personnel Registry (HCPR) Requirements** **What the Rule Requires** G.S. 131E-256 requires that: Facilities must verify the Health Care Personnel Registry (HCPR) prior to employment of any unlicensed staff providing care. The facility must ensure: No individual listed on the HCPR for findings of abuse, neglect, or misappropriation of property is employed in a position involving client care Verification must be: Completed prior to hire Documented and maintained in the personnel record The governing body must ensure compliance with all hiring and registry verification requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 131	Continued From page 50 This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete the Health Care Personnel Registry (HCPR) check prior to hire for 1 of 4 staff (Former Staff (FS #5). The findings are: Review on 03/11/26 of facility records revealed: -No personnel record for FS #5. -No date of hire recorded. -No documented HCPR check for FS #5. Interview on 03/11/26 the Licensee/Registered Nurse stated: -FS #5 was a "shadow staff." -FS #5 was at the facility to "shadow" staff #1. -FS #5 worked at the facility for several days in February 2026. -She had not hired FS #5. -FS #5 no longer worked at the facility. -She paid FS #5 for her work at the facility. -She did not have a HCPR check for FS #5. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 131	**PLAN OF CORRECTION** 1. Immediate Corrective Actions The facility is conducting a 100% audit of all current staff personnel files to verify: -HCPR checks are completed -Documentation is present in each file -Any missing HCPR verifications have been immediately completed and documented. **The facility is ensuring that no current staff have disqualifying findings**. 2. **Policy Revision and Implementation** A. HCPR Verification Policy (REVISED) The governing body is revising the Personnel Policy to require: A Health Care Personnel Registry (HCPR) check must be completed prior to hire for all direct care staff. Documentation of the HCPR check must include: Date of verification Printed or electronic confirmation The HCPR verification must be maintained in the personnel file at all times. **Hiring Policy Implemented:** No staff may: Be hired Work Shadow in a direct care role WITHOUT documented HCPR verification	
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 51 these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is	V 289	B**. Pre-Employment Screening Checklist** **A standardized checklist has been implemented requiring:** -HCPR verification -Criminal background check -Verification of qualifications -Director approval prior to start date C. Personnel File Documentation System (REINFORCED) Personnel files are now organized with a required section for: HCPR documentation Files are reviewed prior to scheduling staff 3. **Implementation Measures** Facility Director verifies HCPR clearance before approving employment Documentation must be present in file before first shift Personnel checklist placed in each file to ensure compliance **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Hiring process enforced (no HCPR = no work) No exceptions for: Temporary staff Shadow staff Contract staff Any missing verification will result in: Immediate removal from schedule Corrective action **MONITORING** (First 90 Days) Weekly audit of all personnel files Verification of HCPR documentation **Ongoing** Monthly personnel audits through QAPI Random file checks by governing body Documentation of audit findings maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 52 developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to operate within the scope of their program by admitting clients without developmental disabilities affecting 2 of 3 audited clients (#1 and #6) and 1 of 1 Former Client (FC #8) and failed to ensure the facility operated as licensed with 6 ambulatory clients for 6 of 6 clients (#1, #2, #3, #4,#5, #6). The findings are: Cross Reference: 10A NCAC 27G .5602 Staff (V290) Based on record review, observation and interview, the facility failed to maintain staffing to respond to and meet the individualized client needs of 6 of 6 current clients (#1, #2, #3, #4, #5, #6). Review on 02/24/26 and 03/11/26 of the Division	V 289	**V289 – 10A NCAC 27G .5601** **Supervised Living – Scope** **What the Rule Requires** 10A NCAC 27G .5601 defines the scope of services for a supervised living facility and requires that: The facility may only admit and serve clients whose needs are appropriate to the level of care and supervision the facility is licensed to provide. The facility must ensure: Clients do not require services beyond the facility's capability The level of supervision, staffing, and clinical oversight matches client needs The governing body must ensure that: Admission decisions are consistent with the facility's license and service capacity Clients are protected from being placed in an inappropriate setting **PLAN OF CORRECTION** The facility is conducting a comprehensive review of all current clients to determine appropriateness of placement. Clients identified as not appropriate for the facility's licensed scope were: Safely discharged, and Assisted with placement in appropriate settings Coordination was completed with: Guardians Referral sources Providers	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 53 of Health Service Regulation (DHSR) records revealed: -The facility is licensed for 6 ambulatory adults with a primary diagnosis of an Intellectual Developmental Disability (IDD). -"Ambulatory: A person who can evacuate the building without physical or verbal assistance during a fire or other emergency." -There was no waiver to serve adults without an IDD diagnosis or non-ambulatory status clients. Review on 02/25/26 of client #1's record revealed: -Date of admission 08/23/25. -Diagnoses: Dementia, Left Leg Below Knee Amputation, Paranoid Schizophrenia, Paraplegia. Cognitive Impairment, Bowel incontinence, Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed, Depressed Mood and Substance Use. -No IDD diagnosis. -FL-2 dated 11/04/25 - client was disoriented intermittently and semi-ambulatory via wheelchair. Review on 03/04/26 of client #2's record revealed: -Date of admission: 05/02/25 -Diagnoses: IDD and Schizophrenia. -FL-2 dated 11/20/25 - client was a wanderer. Review of client #3's record revealed: -Date of admission: 02/22/25 -Diagnoses: IDD Mood Disorder, Type 2 Diabetes, Urinary Incontinence and Hyperlipidemia. -FL-2 dated 11/20/25 - client was disoriented intermittently, had self-injurious behavior and was semi-ambulatory.	V 289	**2. Policy Revision and Implementation** A. Admission and Scope Compliance Policy (REVISED) The governing body is revising the Admission Policy to require: All admissions must include a formal determination of appropriateness based on: Assessment findings Medical and behavioral needs Facility capability **Scope Policy Implemented:** No client may be admitted unless: -The Qualified Professional (QP) confirms appropriateness -The Consultant RN reviews medical needs -The Facility Director approves admission **B. Pre-Admission Screening Tool (NEW)** A standardized screening tool is being implemented requiring evaluation of: -Level of supervision required -Medical complexity -Behavioral health needs -Mobility and ADL needs -Ability of the facility to safely meet those needs **C. Admission Approval Process (NEW)** All admissions require dual review and approval: Qualified Professional (clinical appropriateness) Consultant RN (medical appropriateness, if applicable) Final approval by Facility Director prior to admission **3. Implementation Measures** Admission checklist required and filed prior to admission Documentation of appropriateness maintained in client record Staff educated on identifying inappropriate placements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 54 Review on 02/25/26 of client #4's record revealed: -Date of admission: 05/20/25. -Diagnoses: Major Depressive Affective Disorder, Unspecified IDD, Unspecified Schizophrenia Spectrum, Hypertension, Obesity, Unspecified Anxiety, Unspecified Psychosis. Review on 02/24/26 and 02/25/26 of client #5's record revealed: -Admission date of 02/03/26. -Diagnoses: Autistic Disorder, Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease (GERD), Diabetes type 2, Allergic Rhinitis and Pruritis Rash. -FL-2 dated 03/05/26 - client was intermittently disoriented. Review on 02/25/26 of client #6's record revealed: -Date of admission 02/03/26. -Diagnoses: Muscle Weakness, Major depression, Anxiety disorder, Generalized Pain, Aphasia, Dysphasia. -FL-2 dated 03/31/25 - client was semi-ambulatory with a rollator walker. -No diagnosis of IDD. Review on 02/27/26 of FC #8's record revealed: -Admission date of 02/03/26. -Schizophrenia Post-Traumatic Stress Disorder, Diabetes, Anxiety Disorder, GERD, Hyperlipidemia, Low B12 and Vitamin D. -No diagnosis of IDD. -Discharge date of 02/04/26. Review on 03/11/26 of the DHSR Construction Section survey dated 03/10/26 revealed: "-1. At the time of the survey, a surprise fire drill	V 289	**PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Admission process enforced (no approval = no admission) Clients must meet facility scope at: Admission Ongoing service delivery Any change in client condition will trigger: Reassessment Determination of continued appropriateness If client exceeds scope: Immediate discharge planning initiated **MONITORING** (First 90 Days) 100% review of all admissions Weekly review of: Admission documentation Appropriateness determinations **Ongoing** Monthly admission audits through QAPI Review of any change in client condition Documentation maintained for all audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 55 was performed. There were five clients present in the home at the time of the fire drill. None of the five clients responded or evacuated the home at the time the alarms were activated. This home was licensed as a home for all ambulatory clients. Based on the rule, an ambulatory client must be able to respond and evacuate at anytime the alarms are activated, without staff prompting or assistance. The clients need to be trained to respond and evacuate without staff prompting or assistance at anytime the alarms are activated. If the clients are unable to perform this, they may need to be relocated to another home that is more suited for their needs. The home can also be remodled to accommodate non-ambulatory clients. This would require a project to be submitted to DHSR construction and the addition of sprinklers and fire alarms per Section 428.4 of the 2018 North Carolina State Building Code. Take the necessary steps to bring the home into compliance by implementing one of the above scenarios." Interview on 02/24/26 staff #1 stated: -He worked 2 weeks off and 2 weeks on. Review on 03/04/26 and 03/11/26 of the Plan of Protection (POP) dated 03/04/26 written by the Licensee/RN and QP revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? A- Plan of Protection -30 days discharge notice will be given to [Client #1] to enable him to find a place that can meet with his needs. - [Client #5] will be assessed for Autism by a Psychologist. If client doesn't meet criteria will be discharged. -Describe your plans to make sure the above happens. B - Plans to make sure the above plans Giving [Client #1 initials] a 30 days discharge	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 56 notice to his guardian to find another place to meet his needs. - Assessing every new referral for IDD criteria before admission. - Admitting only clients that meets with IDD criteria." -1- Amended POP dated 03/04/26 "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection - Making an appointment with a psychologist to assess all new referrals to ascertain that they meet criteria for admission per policy. -Describe your plans to make sure the above happens. Plans to make sure the above plans happen - Having appointment with psychologist to assess the clients ([Client #1] and [Client #5])for required criteria for 60 days. - Proper discharging of [Client #1] and [Client #5] if they don't meet criteria with 30 days if they do not meet criteria." -2 - Amended POP dated 03/04/26 "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection Administrator (Licensee/RN) will be assessing clients prior to admission to make sure they meets criteria for admission (IDD and other diagnosis) and make sure staff can meet their needs. -Describe your plans to make sure the above happens. Plan: Administrator will [1] - Assessing every new clients referral at their referring center before admission - Assessing clients need with the QP to make sure that one staff can provide their needs." -3- Amended POP dated 03/11/26) "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Effective today the facility will conduct daily fire drills on varying shifts (to include 1st shift - 7am-3pm, 2nd shift	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 57 (3pm-11pm) and 3rd shift 11pm-7am) within a 3 day period. The facility will contract with someone who will monitor and follow up with implementation/completeion of the drills on a daily basis for 2 weeks (14 days) and then weekly for a period of 60 days. The facility administrator will complete assessment of each clients ability to evacuate without assistance. Any client who is not able to exit with less than verbal prompting will be considered for discharge to a higher level of care. -Describe your plans to make sure the above happens. The facility will contract with an additional QP to oversee implementation of assessments of clients ability to exit the facility during a fire or disaster drill. Additionally, that QP will assist with referral to the appropriate levels of care." -4- Amended POP dated 03/11/26) "Addendum: The facility will hire a 2nd staff to work directly with the clients in this group home. Staff will carry out the responsibilities of providing care in collaboration with the other staff. There will be an awake staff on 3rd shift. there will always be a staff present and available to assist as needed 24 hrs 9 hours) a day, 7 days a week." This facility is licensed for six clients with diagnoses to include Dementia, Left Leg Below Knee Amputation, Paranoid Schizophrenia, Paraplegia, Cognitive Impairment, Bowel Incontinence, Bladder Incontinence, Hypertension, Adjustment Disorder, Depressed Mood, Substance Use, IDD, Mood Disorder, Type 2 Diabetes, Hyperlipidemia, Major Depressive Affective Disorder, Obesity, Unspecified Psychosis, Autistic Disorder, Asthma, GERD, Allergic Rhinitis, Pruritis Rash, Muscle Weakness, Generalized Pain and Aphasia. The Licensee/RN stated the admissions of client #6	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 289	Continued From page 58 and FC #8 on 02/03/26 was on an emergency basis. There was no documentation of assessement's of client #5, client #6 and FC #8 to determine their ability to manage during emergencies, self-care or special needs. She typically would meet the clients at the placement facility, conduct a screening and discuss admission with the Qualified Professional. She did not conduct a screening and admission for clients #6 and #FC#8 prior to their admissions. She did not screen the clients to access if they met criteria. The Licensee/RN accepted responsibility for the lack of planning and the determination if the facility could respond to the needs of the clients and informed that the clients could be trained to exit the facility independently. The facility had one staff to meet all treatment and care needs to include clients with disorientation, incontinent of bladder and bowel and daily hygiene needs. All 6 clients needed various levels of care throughout the day and night. The constant and pungent foul odor throughout the entire facility indicated that client care was not provided as required. The facility did not maintain current license standards for 6 ambulatory clients, the lack of IDD diagnoses and the lack of the current hygiene and personal care assistance needs for the clients. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 59 (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.	V 290	**V290 – 10A NCAC 27G .5602** **Supervised Living – Staffing and Supervision Requirements** **What the Rule Requires** 10A NCAC 27G .5602 requires that: The facility must provide adequate staffing and supervision to meet the needs of clients at all times. Staffing must: Be sufficient in number Be qualified and trained Be appropriate to the acuity and needs of the clients served The facility must ensure: Staff are available to provide continuous supervision Staff are capable of meeting: Personal care needs Medical monitoring needs Behavioral health needs The governing body must ensure that staffing patterns reflect: Client needs Safety requirements Level of supervision required **PLAN OF CORRECTION** The facility is conducting a comprehensive review of all client needs, including: Supervision requirements Medical and behavioral needs ADL assistance needs	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 60 This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to maintain staffing to respond to and meet the individualized client needs of 6 of 6 current clients (#1, #2, #3, #4, #5 and #6). The findings are: Review on 02/25/26 of client #1's record revealed: -Date of admission 08/23/25. -Diagnoses: Dementia, Left Leg Below Knee Amputation, Paranoid Schizophrenia, Paraplegia, Cognitive Impairment, Bowel incontinence, Bladder Incontinence, Hypertension, Adjustment Disorder, Depressed Mood and Substance Use. Review on 03/11/26 of client #1's FL-2 dated 11/04/25 revealed: -Disoriented intermittently. -Incontinent of bladder and bowel. -Personal care assistance in bathing and dressing. -Supply gloves, wipes, pull up and bed pads. -Patient care-Check right foot daily for skin breakdown. Review on 03/04/26 of client #2's record revealed: -Date of admission: 05/02/25 -Intellectual Developmental Disability (IDD) and Schizophrenia. Review on 03/04/26 of client #2's FL-2 dated 11/20/25 revealed: -Inappropriate behavior: Wanderer. -Personal care assistance: bathing and dressing.	V 290	Staffing levels were immediately adjusted to ensure: Adequate coverage on all shifts Appropriate supervision of all clients Staff assignments were revised to ensure alignment with client needs 2**. Policy Revision and Implementation** A. Staffing and Supervision Policy (REVISED) The governing body is revising the Staffing Policy to require: Staffing schedules must be based on: Number of clients Level of supervision required Medical and behavioral needs At all times: Adequate staff must be present to ensure client safety Staff must be: Trained Competent Assigned according to skill level B. Staffing Matrix and Scheduling System (NEW) **A structured Staffing Matrix is being implemented to determine:** -Minimum staffing levels per shift **Additional staffing required based on:** -Client acuity -Mobility limitations -Medical conditions **C. Staff Competency Verification (REINFORCED)** Staff assignments are based on: Verified training Demonstrated competency Staff must not be assigned duties beyond their level of training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 61 -Supply pull ups and gloves. Review of client #3's record revealed: -Date of admission:02/22/2 -Diagnoses of IDD, Mood Disorder, Type 2 Diabetes, Urinary Incontinence and Hyperlipidemia. Review on 03/04/26 of client #3's FL-2 dated 11/20/25 revealed: -Disoriented intermittently. -Inappropriate behavior: self-injurious. -Personal care assistance: Bathing and dressing. -Incontinent of bladder. -Semi-ambulatory. Review on 02/25/26 of client #4's record revealed: -Date of admission: 05/20/25. -Diagnoses: Major Depressive Affective Disorder, Unspecified Intellectual Disability, Unspecified Schizophrenia Spectrum, Hypertension, Obesity, Unspecified Anxiety, Unspecified Psychosis. Review on 03/04/26 of client #4's FL-2 dated 11/20/25 revealed: -Personal care assistance: bathing, feeding and dressing. -Incontinent of bladder. -Supply pull ups, bed pads and gloves. Review on 02/24/26 and 02/25/26 of client #5's record revealed: -Admission date of 02/03/26. -Diagnoses of Autistic Disorder, Paranoid Schizophrenia, Hypertension, Hyperlipidemia, Asthma, Gastroesophageal Reflux Disease (GERD), Diabetes type 2, Allergic Rhinitis and Pruritis Rash.	V 290	**PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Staffing levels must meet or exceed client needs at all times No shift will operate without adequate staff coverage Changes in client condition will trigger: Immediate staffing reassessment Any staffing deficiency will result in: Immediate corrective action Administrative review **MONITORING** (First 90 Days) Weekly review of staffing schedules Verification that staffing matches client needs **Ongoing** Monthly staffing audits through QAPI Review of incident reports related to supervision Documentation of staffing compliance maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 62 Review on 03/11/26 of a client #5's FL-2 dated 03/05/26 revealed: -Intermittently disoriented. -Incontinent of bladder. -Personal care assistance with bathing, dressing and feeding. Review on 02/25/26 of client #6's record revealed: -Date of admission 02/03/26. -Diagnoses: Muscle Weakness, Major depression, Anxiety disorder, Generalized Pain, Aphasia, Dysphasia. Review on 02/24/26 of client #6's FL-2 dated 03/31/25 revealed: -Personal care assistance: bathing, dressing and feeding (cut meats). -Incontinent of bladder and bowel. -Semi-ambulatory with a rollator walker Review on 02/27/26 of client #6's physician orders dated 11/05/25 revealed: -Humalog (insulin) 6 units - 4 times a day with meals and hold for a blood sugar value less than 110. -Notify provider for finger stick blood sugar (FSBS) less than 70 or greater than 400. Observation on 02/24/26 at approximately 11:00am revealed: -Staff #1 opened the front door to the facility. -A pungent, persistent and permeating smell of urine was detected throughout the entire facility. Interview on 02/25/26 client #6 at local hospital Intensive Care Unit (ICU) revealed: -"...had diabetes all my life, 130 is good, don't remember them (staff) checking it (blood sugar value) at the group home	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 63 -Started having problems, started throwing up on Sunday (02/22/26) -I couldn't get off the floor by myself, didn't get checked on. Sunday (02/22/26). -"I wear pull-ups." -Meals, not eating right, basically pizza and what was in front of me, spaghetti, corn dogs, bologna sandwiches... -"It should be against the law for them to do me the way they did me." Interview on 02/25/26 client #6's sister/legal guardian stated: -"Most of the visits to the group home he (client #6) was not clean, could smell the urine on him. His clothes not clean, been there (group home) two times." -"His pants smelled so bad with urine smell; I took took [client #6]'s pants home to wash them and washed them several times and still couldn't get the urine stink out." - No pull ups in his size. "I took him some out of my car, he has accidents bowel poops, out of no where...she [Licensee/RN] said he has BMs (bowel movements) on himself." Interview on 02/24/26, 02/27/26 and 03/04/26 staff #1 stated: -He worked 2 weeks on and 2 weeks off. -Client #6 went to the day program 5 days and they would not take him back due to his care needs. -Client #6 had to have his blood sugar checked 4 times a day. -Client #1 had to be ready to leave the facility around 6:30am or 7:00am. -He assisted client #1 as needed. -Client #1 uses the bathroom on the bed, on a pad and when he uses it on him I bathe him at his bed...I'm working with what I'm given here..."	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 64 -Client #1 "*isse* all the time, he wears a diaper and *isse* he is in a wheelchair..." -Client #1 uses a bathing bucket at his bed...and has a urinal, does not shower. Interview on 03/11/26 the Qualified Professional stated: -Client #1 can take the Baclofen at 8am in the morning and at 11pm before he goes to bed. -She did not "think it was a good idea" to accept client #1 into the facility until he showed he could "take care" of himself. -She was not aware that client FC #8 was admitted to the facility until after the admission. -She did not know about client #6 until he was in the hospital, when "he went to the hospital is when I found out he was here..." -Client #6 "I reviewed his record, diagnosis of diabetes, no IDD, I found no reason why we should have admitted him with several types of insulin...I told [Licensee/RN] that someone on insulin you need to have more training, red fags absolutely, special staff or intense training... [Licensee/RN] told me everything was ok with him..." -I wasn't aware he (client #6) wasn't getting insulin or Blood Sugar checks, if he wasn't, I wasn't told..." Interview on 02/24/26 and 02/27/26 the Licensee/Registered Nurse stated: -Client #6 and FC #8 were brought to the facility in the morning hours of 02/03/26 from a rest home in a county two hours away. -She only admitted the clients as "an emergency." -She made a "mistake to take them (admit to facility, (client #6 anf FC #8)...they (rest home staff) just brought them to me...I wasn't here to assess, just dropped here..." -She did not call Adult Protective Services to	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 290	Continued From page 65 notify them a provider (rest home) had dropped off clients. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290	2**. Policy Revision and Implementation** A. Restrictive Intervention Training Policy (REVISED) The governing body is revising the training policy to require: All staff must complete training in: Alternatives to restrictive interventions De-escalation techniques Training must be completed: Prior to working independently Annually thereafter Training Policy Implemented: No staff may provide direct care without: Completed training Documented competency **B. Crisis Prevention Training Program** A structured training program is being implemented including: Nonviolent Crisis Intervention (NCI) or equivalent training Techniques for: Verbal de-escalation Behavior management Crisis prevention C**. Competency Validation Process** Staff must demonstrate: Ability to de-escalate situations Knowledge of non-restrictive interventions Competency must be: Observed Documented Signed off by supervisory staff	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or	V 291		04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 291	Continued From page 66 safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals responsible for the client's treatment affecting 2 of 3 audited clients (#1 and #6). The findings are: Finding #1: Review on 02/24/26 and 02/27/26 of client #6's record revealed: -Admission date of 02/03/26. -Diagnoses of Muscle Weakness, Major Depressive Disorder, Anxiety, Diabetes, Aphasia and Dysphasia. Review on 02/27/26 of client #6's physician orders dated 11/05/25 revealed: -Humalog (insulin) 6 units - 4 times a day. Administer if blood sugar was greater than 110. Review on 02/24/26 of a document of client #6's blood sugar value checks at 12pm revealed: -02/12/26 - 12 noon - "F" (at day program per staff #1). -02/13/26 - 12 noon - "F." -02/14/26 - 12 noon - "F." -02/16/26 - 12 noon - "F." -02/17/26 - 12 noon - "F." Interview on 02/24/26 staff #1 stated: -He stated "F" on the blood sugar sheet indicated client #6 was the day program. -Client #6 went to the day program 5 days. Finding #2:	V 291	**V291 – 10A NCAC 27G .5603** **Supervised Living – Operations** **What the Rule Requires** 10A NCAC 27G .5603 requires that: The facility must ensure effective operation of services to meet the needs of each client. The facility must: Provide care, supervision, and services in accordance with the Person-Centered Plan (PCP) Ensure coordination of care with: Physicians Mental health providers Day programs and other service providers The facility must ensure: Communication between all providers involved in the client's care Continuity and consistency of services The governing body must ensure that operational systems support: Implementation of PCPs Ongoing coordination and documentation of care **PLAN OF CORRECTION** The facility conducted a review of all current client services and provider involvement. Communication has been established with all relevant providers, including: Medical providers Behavioral health providers Day programs Client records have been updated to include documentation of coordination of care. **2. Policy Revision and Implementation** **A. Coordination of Care Policy (REVISED)** The governing body is revising the Operations Policy to require: The facility must maintain ongoing communication with all providers involved in client care All services must be: Delivered in accordance with the PCP Coordinated across providers Documentation of coordination must include: Provider contacts Updates on client status Follow-up actions	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 291	Continued From page 67 Review on 02/24/26 of client #1's record revealed: -Admission date of 10/28/25. -Diagnoses of Dementia, Left Below the Knee Amputation, Paraplegia, Schizoaffective Disorder, Bipolar Disorder, Chronic Kidney Disease, Cognitive Impairment, Bowel and Bladder Incontinence, Hypertension, Adjustment Disorder with Mixed Anxiety, Depressed Mood, Motor Vehicle Accident, Cannabis Dependence and Alcohol Dependence. Review on 02/24/26 and 02/25/26 of client #1's medication orders dated 11/20/25 revealed: -Baclofen (muscle relaxant) - three times a day. Review on 03/11/26 of client #1's February 2026 Medication Administration Record revealed: -Baclofen three times a day at 8am, 2pm and 8pm. -"F" written in the following 2pm medication times: 02/02 thru 02/07, 02/09 thru 02/14, 02/16 thru 02/18, 02/23 and 02/24. Review on 02/25/26 of client #1's medications revealed: -Baclofen was in a separate perforated daily pill bubble pack with 2pm print on the seal. Interview on 02/24/26 and 03/04/26 the Licensee/Registered Nurse stated: -She was not responsible for client #6's care when he was away from the facility. -She was not responsible for client #6's medications if he was out of the facility at the day program. -She had not coordinated with the day program regarding client #6's blood sugar checks or potential insulin injections. -Client #1 went to the day program Monday thru	V 291	**B. Communication and Coordination System** **A structured system is being implemented requiring**: -Daily Communication Log: -Tracks communication between facility staff and external providers -Provider Contact Log: -Documents all contacts with physicians, therapists, and programs -Care Coordination Notes: -Maintained in each client record **C. PCP Implementation Oversight (REINFORCED)** Staff must follow all interventions outlined in the PCP QP reviews PCP implementation regularly Any gaps in service delivery must be addressed immediately **3. Implementation Measures** Staff document all coordination efforts in client records QP conducts regular reviews of service delivery Facility Director ensures communication systems are maintained **PREVENTION OF RECURRENCE** **To ensure this deficiency does not recur:** All provider interactions will be documented Services must be delivered consistently according to PCP Any lack of coordination will result in: Immediate follow-up Corrective action **Changes in client condition must trigger:** Communication with providers PCP updates **MONITORING** (First 90 Days) Weekly review of: Communication logs	

		V 291	Continued From page 72 Coordination notes Verification that: All providers are contacted as needed Documentation is complete **Ongoing** Monthly audits through QAPI Random review of client records Documentation of coordination maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4	24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 291	Continued From page 68 Friday and returned back to the group home at various hours after approximately 3:30pm. -She had not coordinated with the day program regarding client #1's 2pm dose of Baclofen. -Client #1 is given his 2pm medication after he returned home from the day program. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.	V 536	**V536 – 10A NCAC 27E .0107** **Training on Alternatives to Restrictive Interventions** **What the Rule Requires** 10A NCAC 27E .0107 requires that: All staff must receive training in alternatives to restrictive interventions prior to providing services. Training must include: Techniques to prevent and de-escalate crisis situations Strategies to avoid the use of seclusion, restraint, or restrictive interventions Staff must demonstrate: Understanding of client rights Ability to use non-restrictive interventions safely and effectively The facility must ensure: Staff competency is verified Training is documented and maintained in personnel records	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	**2409 BEL AIR AVENUE SE WILSON, NC 27893**

(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
V 536	Continued From page 69 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail);	V 536	**PLAN OF CORRECTION** All current staff will complete training in alternatives to restrictive interventions, including: Crisis prevention De-escalation techniques Staff competency has been verified through: Observation Skills demonstration Documentation of training has been placed in personnel files. 2**. Policy Revision and Implementation** **A. Restrictive Intervention Training Policy (REVISED)** The governing body is revising the training policy to require: All staff must complete training in: Alternatives to restrictive interventions De-escalation techniques Training must be completed: Prior to working independently Annually thereafter Training Policy Implemented: No staff may provide direct care without: Completed training Documented competency B**. Crisis Prevention Training Program** A structured training program is being implemented including: Nonviolent Crisis Intervention (NCI) or equivalent training echniques for: Verbal de-escalation Behavior management Crisis prevention	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 536	Continued From page 70 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once	V 536	**C. Competency Validation Process** Staff must demonstrate: Ability to de-escalate situations Knowledge of non-restrictive interventions Competency must be: Observed Documented Signed off by supervisory staff 3. **Implementation Measures** Training records maintained in personnel files Staff are monitored during interactions with clients Supervisory staff provide guidance and feedback **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: No staff will work without required training and competency validation Training completion is required prior to scheduling Any staff lacking training will be: Removed from schedule Retrained immediately **MONITORING** (First 90 Days) Weekly review of training records Verification of competency documentation **Ongoing** Monthly training audits through QAPI Observation of staff-client interactions Documentation of compliance maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 536	Continued From page 71 annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 3 current staff (Qualified Professional (QP)) and 1 of 1 former staff (FS) (#5) had annual or initial refresher training in alternatives to restrictive intervention. The findings are:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 536	Continued From page 72 Review on 03/11/26 of facility records revealed: -No personnel record for FS #5. -No date of hire recorded. -No Non-Violent Crisis Intervention (NCI) training in alternatives to restrictive intervention. Review on 02/27/26 of the QP's record revealed: -Hire date 12/12/24. -NCI training in alternatives to restrictive intervention expired 02/05/26. Interview on 02/27/26 and 03/11/26 the Licensee/Registered Nurse stated: -FS #5 was a "shadow staff". -FS #5 was at the facility to "shadow" staff #1. -FS #5 was only at the facility for several days in February 2026. -She had not hired FS #5. -FS #5 did not have any training in alternatives to restrictive interventions. -Staff should have NCI refresher training in alternatives to restrictive interventions every year. -She would ensure the QP had refresher training in alternatives to restrictive interventions in NCI. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives	V 537		04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF IX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	Continued From page 73 to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using	V 537	**V537 – 10A NCAC 27E .0108** **Use of Seclusion, Restraint, and Time-Out** **What the Rule Requires** 10A NCAC 27E .0108 requires that: Seclusion, restraint, or time-out may only be used in accordance with strict regulatory requirements and only when necessary to ensure safety. Staff must: Be trained and competency-validated prior to implementing any restrictive intervention Use restrictive interventions only as a last resort The facility must ensure: All interventions are properly authorized and documented Client rights are protected at all times Continuous monitoring of the client during any intervention The governing body must ensure: Policies and procedures are in place Staff are trained and compliant **PLAN OF CORRECTION** All staff will complete Nonviolent Crisis Intervention (NCI) or equivalent training addressing: Use of seclusion, restraint, and time-out Safety procedures and client monitoring Staff competency has been verified through: Skills demonstration Observation by qualified supervisory staff Documentation of training and competency has been placed in personnel files.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 537	Continued From page 74 concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning	V 537	2. **Policy Revision and Implementation** **A. Restrictive Intervention Policy (REVISED)** The governing body is revising the policy to require: Seclusion, restraint, or time-out may only be used: As a last resort When less restrictive interventions have failed Only staff who are: Trained and competency validated may implement such interventions Policy Implemented: No staff may: Participate in or implement any restrictive intervention WITHOUT documented training and competency **B. Training and Certification Requirement** All direct care staff must complete: NCI or equivalent training Certification must be: Completed prior to independent work Maintained and renewed as required **C. Documentation and Oversight System** All incidents involving restrictive interventions must include: Detailed documentation Review by supervisory staff Incident reports must be: Reviewed for compliance Used for quality improvement 3**. Implementation Measures** Training records maintained in personnel files Staff competency verified prior to assignment Supervisory staff monitor use of interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 537	Continued From page 75 objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and	V 537	**PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: No staff will implement restrictive interventions without certification All interventions must be: Properly authorized Documented Any violation of policy will result in: Immediate corrective action Retraining **MONITORING** (First 90 Days) Weekly review of training records Verification of staff certification and competency **Ongoing** Monthly audits through QAPI Review of incident reports Monitoring of compliance with intervention policies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 537	Continued From page 76 (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 current staff (Qualified Professional (QP)) and 1 of 1 former staff (FS) (#5) received annual or initial training in seclusion, physical restraint and isolation time out. The findings are: Review on 03/11/26 of facility records revealed: -No personnel record for FS #5. -No date of hire recorded. -No Non-Violent Crisis Intervention (NCI) training in seclusion, physical restraint and isolation time out. Review on 02/27/26 of the QP's record revealed: -Hire date 12/12/24. -NCI training in seclusion, physical restraint and isolation time out expired 02/05/26. Interview on 02/27/26 and 03/11/26 the	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 537	Continued From page 77 Licensee/Registered Nurse stated: -FS #5 was a "shadow staff". -FS #5 was at the facility to "shadow" staff #1. -FS #5 was only at the facility for several days in February 2026. -She had not hired FS #5. -FS #5 did not have any training in seclusion, physical restraint and isolation time out. -Staff should have yearly NCI refresher training in seclusion, physical restraint and isolation time out. -She would ensure staff had refresher training in seclusion, physical restraint and isolation time out in NCI. This deficiency is cross referenced into 10A NCAC 27G .0205 (V109) for a Type A1 rule violation and must be corrected within 23 days	V 537		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary	V 540	**V540 – 10A NCAC 27E .0101–.0104 Client Rights – Protection, Dignity, and Humane Care** **What the Rule Requires** 10A NCAC 27E .0101–.0104 requires that: All clients must be treated with dignity, respect, and humane care at all times. The facility must ensure protection of client rights, including: The right to receive care in a safe and clean environment The right to privacy and confidentiality The right to be free from neglect, abuse, or exploitation The facility must ensure: Services are provided in accordance with the client's needs Staff respect client autonomy and individual needs The governing body must ensure: Policies and practices protect client rights Staff are trained and compliant with all client rights requirements	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 540	Continued From page 78 napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on observation and interview the facility failed ensure privacy during the provision of personal hygiene and grooming care for 2 of 3 audited clients (#1 and #4). The findings are: Observation on 02/24/26 at 11:00am revealed: -The hallway bathroom shower did not drain when water was turned on. Interview on 02/25/26 client #1 stated: -He was in the bedroom when clients (#2, #3, #5, #6) completed their hygiene in the master bedroom/bathroom. -He was not "bothered" by the other clients that showered in his master bedroom/bathroom. Interview attempted on 02/24/26 with client #4 revealed: -Client #4 was unable to participate in interview. He would only repeat what was stated to him and would respond with rambling statements or phrases, that were not in context with the subject matter that was presented. Interview and on 02/24/26 and on 02/25/26 staff #1 stated: -Client #1 "p***y all the time, he wears a diaper and p***y he is in a wheelchair..."	V 540	**PLAN OF CORRECTION** All clients are being re-assessed to ensure: Personal care and hygiene needs are being met Services are delivered in a respectful and dignified manner Staff have been immediately re-educated on: Client rights Dignity and respect in care delivery Any identified deficiencies in care have been corrected immediately **2. Policy Revision and Implementation** **A. Client Rights Policy (REVISED)** The governing body is revising the Client Rights Policy to require: All clients must be treated with: Dignity Respect Consideration of individual needs Staff must: Provide assistance with hygiene and personal care as needed Protect client privacy and confidentiality Any violation of client rights must be: Reported immediately Investigated and addressed **B. Client Care and Dignity Standards** A structured standard is being implemented requiring: All care must: Meet basic human needs (hygiene, safety, comfort) Be delivered in a respectful manner Staff must ensure: Clients are clean, appropriately dressed, and cared for Clients are treated as individuals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 540	Continued From page 79 -Client #1 "uses the bathroom "on the bed, a pad and when I bathe him at his bed...I'm working with what I'm given here..." -Client #1 used a bathing pan "at his bed"...and "has a urinal," he did not use "the shower." -The bedroom hallway shower did not drain. -The only available bathroom was in client #1 and client #4's bedroom. -The other clients took a shower in client #1 and client #4's master bedroom/bathroom. -He also showered in client #1's and client #4's master bedroom/bathroom. Interview on 03/11/26 the Qualified Professional stated: -She had no knowledge the hallway bathroom did not work. Interview on 02/25/26 the License/Registered Nurse stated: -She did not know that the shower did not work in the hallway bathroom. -She did not know that the clients (#2, #3, #5, #6) and staff used one bathroom, located in client #1 and client #4's master bedroom/bathroom. -She would have a plumber to repair the hallway shower.	V 540	**C. Rights Awareness and Reporting System** **Client rights are:** Posted in the facility Reviewed with clients and staff A reporting process has been implemented for: Allegations of neglect or rights violations 3. **Implementation Measures** Staff provide daily care consistent with client rights Supervisory staff monitor care delivery Any concerns are addressed immediately **PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Client rights are reinforced as a core standard of care Staff must follow: PCPs Hygiene and care protocols Any violation of client rights will result in: Immediate corrective action Staff retraining or disciplinary action **MONITORING** Short-Term (First 90 Days) Weekly review of client care and hygiene Observation of staff interactions with clients **Ongoing** Monthly audits through QAPI Review of any complaints or incidents Random observation of care practices	
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record reviews, observations and	V 736		04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 80 interviews, the facility and its grounds were not maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. The findings are: Observation on 03/04/26 at approximately between 3:16pm and 3:19pm and on 02/24/26 at approximately 11:37am and 2:41pm the photographs of the facility revealed: -A pack of adult briefs stored on the floor in client #1 and client #4's bedroom floor. -Client #4's clothes hamper and the bed was stored horizontally in front of the window preventing easy access and egress to 2 windows. -Client #5 and client #6's beds and dresser prevented easy access and egress from the three windows in the room. -Client #5's sheet had holes in the fabric. -2 various sizes of brown water stains on the white ceiling in client #5 and client #6's bedroom. -Client #5 and client #6's bedroom door had various sizes of paint peeled away from the surface. -A blue five gallon bucket with water was stored in the hallway shower. -The front entrance counter had two corners broken and separated on the end. -The transition between the kitchen area and living room transition doorway had broken and uneven concrete. -The hallway bathroom had 1 of 8 bulbs missing in the light socket. -The hallway shower had a brown build up of substance near the bottom in the grout. -The hallway toilet had brown stains below the water level. -The bathroom for client #1 and #4 had 2 of 7 light bulbs missing in the sockets. Only one light bulb worked. -The brown kitchen ceiling had a softball sized	V 736	**10A NCAC 27G .0302** **Facility Design and Physical Environment** **What the Rule Requires** 10A NCAC 27G .0302 requires that: The facility must be designed, constructed, maintained, and equipped to ensure the health, safety, and well-being of clients. The environment must be: Safe Clean and sanitary Free of hazards The facility must ensure: Equipment and building systems are in good working order Adequate lighting, ventilation, and temperature control Safe accessibility and mobility throughout the facility The governing body must ensure: Ongoing monitoring and maintenance systems are in place Environmental risks are identified and corrected promptly **PLAN OF CORRECTION** A comprehensive environmental safety inspection of the entire facility was conducted by: Facility Director Consultant RN All identified environmental concerns were: Corrected immediately Cleaned, repaired, or removed as needed **2. Policy Revision and Implementation** **A. Environmental Safety and Maintenance Policy (REVISED)** The governing body is revising the Environmental Policy to require:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 81 white patched area on the surface. -A picture frame in the living room had a broken missing shard of glass in the left corner. -The entrance to the facility was built up by concrete on the threshold. -The front glass storm door was smeared with a cloudy substance. Observation on 03/04/26 of photographs at approximately 3:17pm of the facility on 03/04/26 revealed: -3 fire ant mounds in the front yard of the facility. Observation on 02/24/26 at approximately 11:00am revealed: -Staff #1 opened the front door to the facility and a foul, pungent and repulsive smell of urine which permeated inside and throughout the entire facility was detected. -The foul urine stench was consistent and permeated the entire facility and made it difficult to breathe. -Client #5 and #6's ceiling fan had a thick layer of dust buildup on each of the fan blades. A baseball sized water stain was in the corner of the ceiling. The bedroom door had various sizes of paint peeled off the surface on the bottom half, from less than one half to one inch in size. -Client #2 and client #3's bedroom door had an approximately 12 inch section of masking tape on the white surface. -5 smoke detectors emitted a chirping sound every 35 seconds. The alarms beeped at various times during the entire approximately 7 hours onsite. -Client #1 and client #4's bedroom had a package of adult briefs on the floor. -The kitchen had an approximately 8 inch by 8 inch white patch on the ceiling. -The kitchen and facility had various sizes of bits	V 736	The facility must be maintained in a: Safe Clean Hazard-free condition at all times Environmental issues must be: Identified immediately Reported and corrected without delay **B. Preventative Maintenance Program (NEW)** **A structured Preventative Maintenance Program is being implemented, including:** **Monthly Environmental Inspection Checklist, addressing:** Fire safety equipment Water temperature and plumbing Electrical systems Floors, walls, and structural safety Cleanliness and sanitation Lighting and ventilation All inspections are: Documented Signed and dated Maintained on-site **C. Daily Environmental Safety Checks** Staff are required to complete daily safety checks each shift, including: Identification of hazards (spills, broken items, obstructions) Cleanliness of client areas Any issues must be: Reported immediately Documented and corrected the same day **3. Implementation Measures** Environmental checklists placed in facility Staff assigned responsibility for daily monitoring Maintenance issues tracked and resolved promptly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 82 of debris and food on the floors throughout the entire facility. -The rear room had an approximately golf ball sized hole in the sheetrock and a wet mop stored. -The room which housed the dryer had too many to count, various sized wood particles which were scattered on the floor. Observation on 02/25/26 at approximately 10:00am revealed: -Smoke detectors throughout the facility continued to emit a chirping sound. -The foul offensive urine stench was consistent and permeated throughout the entire facility was mixed with a strong odor of a cleaning product. Observation on 02/27/26 at approximately 9:25am revealed: -Smoke detectors throughout the facility continued to emit a chirping sound. -The foul urine smell was consistent and permeated throughout the entire facility mixed with a strong odor of a cleaning product Interview on 02/25/26 client #6 at local hospital Intensive Care Unit (ICU) revealed: -"Fire alarms need some batteries, sound like a canary." Interview on 02/25/26 client #6's sister/legal guardian stated: -"Most of the visits to the group home he (client #6) was not clean, could smell the urine on him. His clothes not clean, been there (group home) two times." -"His pants smelled so bad with urine smell; I took [client #6]'s pants home to wash them and washed them several times and still couldn't get the urine stink out."	V 736	**PREVENTION OF RECURRENCE** To ensure this deficiency does not recur: Daily and monthly environmental monitoring systems are enforced All hazards must be: Identified Reported Corrected immediately Any failure to maintain environmental safety will result in: Immediate corrective action Staff retraining **MONITORING** (First 90 Days) Weekly review of environmental logs Verification that all hazards are corrected timely **Ongoing** Monthly environmental audits through QAPI Random facility inspections by governing body Documentation maintained for survey review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 83 - No pull ups in his size. "I took him some out of my car, he has accidents bowel poops, out of no where...she [Licensee/RN] said he has BMs (bowel movements) on himself." Interview on 02/24/26, 02/27/26 and 03/04/26 staff #1 stated: -He worked 2 weeks on and 2 weeks off. -There is one staff per shift. -He did not hear the smoke detectors beeping. The batteries had been changed previously. -He assisted client #1 as needed. -Client #1 uses the bathroom on the bed, on a pad and when he uses it on him I bathe him at his bed...I'm working with what I'm given here..." -Client #1 "p***y all the time, he wears a diaper and *p***y* he is in a wheelchair..." -Client #1 used the bathroom on the bed, on a pad and when he uses it on him I bathe him at his bed...I'm working with what I'm given here..." -Client #1 used a bathing bucket at his bed...and has a urinal, does not shower. Interview on 2/24/26 the Qualified Professional stated: -The smell, "yes never smelled it this bad, urine, staff not cleaning up as good as they should." Interview on 02/24/25, 02/25/26 and 3/4/26 the Licensee/Registered Nurse (Registered Nurse)stated: -The "kind of people we have, they be peeing when they come in." -The clients only wear under garments when they have accidents or go to the programs. -"...They know when to go pee, that doesn't mean we neglect them, they are men they pee on the floor and staff didn't mop, mops not washed, smell is coming down. -The batteries had been changed in the smoke	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 84 detectors, but they kept chirping. -The "smell was coming down." Review on 03/04/26 of the Plan of Protection (POP) dated 03/04/26 written by the Licensee/RN (Registered Nurse) revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection Administrator (Licensee/RN) will maintain a safe and clean environment free of offensive odor for clients to live. Describe your plans to make sure the above happens. Plan - Administrator will supervise staff every quarter to ensure a quarterly fire disaster drill done and documented to encourage client escape at all times. Administrator will supervise staff weekly on house cleaning to maintain clean and odor free environment." Amended POP dated 03/04/26 written by the Licensee/RN revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Plan of Protection - Administrator will maintain a safe and clean environment free of offensive odor for clients to live by providing an obstacle free doors and windows maintaining that fire/disaster drills are done and documented. Describe your plans to make sure the above happens. Plan - Administrator (Licensee/Re will retrain staff on proper cleaning of the house and supervise staff weekly to maintain clean and odor free environment. Administrator will supervise staff every quarter to ensure a quarterly fire [and] disaster rill done and documented to encourage client escape at all times. Administrator will ensure that staff keeps all doors and windows free of obstacles, dry floors for safety."	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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
V 736	Continued From page 85 This facility is licensed for 6 clients with diagnoses to include Dementia, Left Leg Below Knee Amputation, Paraplegia, Cognitive Impairment, Bowel incontinence, Bladder Incontinence, Hypertension, Diabetes, Adjustment Disorder with Mixed, Substance Use, Major Depressive Affective Disorder, Unspecified Intellectual Disability, Unspecified Schizophrenia Spectrum, Hypertension, Obesity, Unspecified Anxiety, Unspecified Psychosis., Muscle Weakness, Major Depression, Anxiety Disorder, Generalized Pain, Aphasia, Dysphasia, Post-Traumatic Stress Disorder, Gastroesophageal Reflux Disease, Hyperlipidemia, Low B12 and Vitamin D, History of Hypothermia. The foul odor which permeated throughout the facility was pungent upon the entrance date and persisted until the exit date of 03/11/26. The clients bedroom furniture was placed in front of the windows and prevented egress. The clients had various ambulatory abilities and cognitive impairments which made the egress within the bedrooms obstructed because of the furniture placement which blocked the windows. The uncleanliness of the facility was evident throughout all the rooms in the facility. The smoke detectors chirped for multiple days and was not addressed immediately and had not worked for an undetermined amount of time. There was only one staff who worked per shift for the clients to assist during the window egress, to ensure the hygiene of the clients and cleanliness of the facility and the lack of functionality of the smoke detectors and the inability for the clients to exit for emergencies independently was a safety risk which attributed to the serious neglect of each client in the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-218	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINKLE-STAR HOME SERVICES #4 24091	2409 BEL AIR AVENUE SE WILSON, NC 27893

(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

FROM: TWINKLE-STAR HOME SERVICES #4

TOPIC: POC

TO: SOUTH COASTAL TEAM

MENTAL HEALTH LICENSURE

DIVISION OF HEALTH SERVICE REGULATION

NC DEPT OF HEALTH AND HUMAN SERVICES

FAX: 919-715-8078

Statement of Substantial Compliance and Request for Retention of License

Twinkle Star Home #4

2409 Bell Air Avenue, Wilson, NC

To: North Carolina Department of Health Service Regulation

Adult Care Licensure Section

Twinkle Star Home #4 respectfully submits this formal statement in response to the Statement of Deficiencies (SOD) issued following the survey completed on March 11, 2026.

The facility acknowledges the seriousness of the cited deficiencies and affirms its full commitment to immediate, sustained, and verifiable compliance with all applicable North Carolina Administrative Code rules and General Statutes governing 10A NCAC 27G Supervised Living Facilities. This statement is submitted in conjunction with the detailed Plan of Correction (POC) and is intended to demonstrate that the conditions which led to the deficiencies have been decisively corrected and that robust systems are now in place to ensure ongoing compliance and protection of client health, safety, and rights.

I. Fundamental Organizational Restructuring and Governance Reform

Effective immediately upon identification of the deficiencies, Twinkle Star Home #4 implemented a complete restructuring of its governing and operational oversight to align with 10A NCAC 27G .0201–.0203 Governing Body and Operational Management Requirements.

The facility has established a new governing body consisting of:

A Consultant Registered Nurse (RN) responsible for clinical oversight, medication management systems, and health-related compliance;

A Qualified Professional (QP) responsible for assessment, service planning, supervision of care, and compliance with 10A NCAC 27G .0205 and .0206;

A newly appointed Facility Director responsible for daily operations, staffing compliance, and implementation of governing policies.

Additionally, the owner has been fully removed from all operational and clinical decision-making, and will function strictly in a non-operational ownership capacity. This separation ensures compliance with governance standards requiring clear delegation of authority, accountability, and qualified supervision.

This restructuring directly addresses deficiencies cited under:

10A NCAC 27G .0201 Governing Body Policies (failure to implement admission and quality systems)

10A NCAC 27G .0202 Personnel Requirements (lack of personnel records and qualifications)

10A NCAC 27G .0203 Competencies of Qualified Professionals

The new governing body meets daily for the first 90 days, conducting documented reviews of:

Admissions

Client care

Medication administration

Incident reports

Staffing compliance

Thereafter, oversight will occur monthly with formal quality assurance reporting, ensuring sustained compliance.

II. Immediate Correction of Admission and Population Compliance Issues

In direct response to findings under 10A NCAC 27G .5601 (Scope) and .5602/.5603 (Staffing and Operations), the facility identified that certain residents admitted were not appropriate for the licensed population.

Corrective actions taken include:

Immediate discharge of all residents not appropriate for the facility's licensed population, specifically those requiring placement in a 27G .5601C facility;

Coordination with referral sources, guardians, and providers to ensure safe and appropriate placement transitions;

Implementation of a strict pre-admission screening protocol, requiring:

QP assessment prior to admission

RN review of medical needs

Verification of facility capability to meet client needs before acceptance

These actions ensure full compliance with:

10A NCAC 27G .0205 Assessment and Treatment Planning

10A NCAC 27G .5601 Scope requirements

G.S. 131E-256(d2) regarding appropriate care and protection of residents

III. Comprehensive Staff Training and Competency Verification

Twinkle Star Home #4 has implemented immediate and ongoing staff retraining, addressing deficiencies cited under:

10A NCAC 27G .0202 Personnel Requirements

10A NCAC 27G .0209 Medication Requirements

10A NCAC 27E .0107 and .0108 Client Rights and Restrictive Interventions

Actions include:

Completion of mandatory training for all staff prior to continued or new assignment, including:

Client rights

Infection control

Medication administration

Emergency response and evacuation

Alternatives to restrictive interventions

Implementation of competency-based testing and skills validation

Establishment of personnel files containing all required documentation, including credentials, training records, and background checks

No staff are permitted to work independently without verified competency and documentation, correcting prior deficiencies related to untrained and undocumented staff.

IV. Implementation of Clinical Oversight and Quality Assurance Systems

The facility has developed and implemented a comprehensive Quality Assurance and Performance Improvement (QAPI) Program, directly addressing failures cited under 10A NCAC 27G .0201 (quality improvement and clinical oversight).

Key components include:

RN-led medication management audits (daily MAR review, storage compliance, labeling verification)

QP-led assessment and service plan audits

Weekly client record audits to ensure compliance with 10A NCAC 27G .0206

Monitoring of:

Blood glucose checks

Medication administration accuracy

Incident and emergency response documentation

All deficiencies related to medication administration, documentation, and coordination of care will be addressed through:

Structured medication administration systems

Locked and properly labeled medication storage

Clear coordination protocols between facility staff and external providers (e.g., day programs)

V. Strengthening of Client Protections and Rights

Twinkle Star Home #4 affirms its commitment to full compliance with:

10A NCAC 27E .0107 (Training on Alternatives to Restrictive Interventions)

10A NCAC 27E .0108 (Seclusion, Restraint, and Time-Out)

Corrective actions include:

Immediate retraining of all staff on client rights and dignity protections

Prohibition of any unauthorized or untrained intervention

Implementation of incident review protocols to ensure accountability and prevention of recurrence

VI. Environmental Safety, Emergency Preparedness, and Supervision

Deficiencies related to emergency preparedness and supervision (including evacuation capability and staffing levels) have been corrected through:

Implementation of quarterly disaster drills on all shifts

Development of individualized evacuation plans

Increased staffing levels to meet client needs in accordance with 10A NCAC 27G .5602

Ongoing evaluation of client mobility and supervision needs

VII. Measures to Prevent Recurrence

Twinkle Star Home #4 has implemented systemic safeguards to ensure that deficiencies do not recur:

Daily Monitoring (First 90 Days)

Governing body review of all critical operational areas

Monthly Compliance Audits (Ongoing)

Formal QA reports and corrective tracking

Admission Control System

No admission without QP and RN approval

Staff Accountability System

Immediate corrective action for any non-compliance

External Oversight

Consultant RN and QP maintain independent authority to enforce compliance

VIII. Commitment to Compliance and Request for Consideration

Twinkle Star Home #4 acknowledges that the deficiencies cited were serious and required immediate and decisive action. The facility has responded with comprehensive structural reform, clinical oversight, staff retraining, and strict compliance systems that collectively demonstrate:

The deficiencies have a plan of correction;

The root causes have been identified and eliminated;

Sustainable systems are being put in place to ensure ongoing compliance.

IX. Formal Request

In light of the immediate and comprehensive corrective actions taken, Twinkle Star Home #4 respectfully requests that the Department:

Recognize the facility's good faith efforts and substantial compliance;

Allow continued operation under enhanced monitoring as deemed appropriate;

Refrain from revocation of the facility's license, as the conditions leading to deficiencies no longer exist and have been replaced with compliant and sustainable systems.

Twinkle Star Home #4 remains fully committed to providing safe, appropriate, and high-quality care to all residents and to maintaining full compliance with all regulatory requirements.

Respectfully submitted,

Twinkle Star Home #4

Governing Body & Administration