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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
	FCL092236	A. BUILDING: _____ B. WING _____	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE INNOVATIONS OF NORTH CAROLINA	2409 HORTON ROAD KNIGHTDALE, NC 27545

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/27/26.	C 000		
C 105	10A NCAC 13G .0317 (d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) Hot water shall be supplied to the kitchen, bathrooms, and laundry. The hot water temperature shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F at all fixtures used by or accessible to residents. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 1 of 3 fixtures which were used by residents with hot water temperatures ranging from 116.2°F to 120°F. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed as a Family Care Home facility with a capacity of 4 beds. Review of the facility's census report for 03/27/26	C 105	Facility shall maintained hot water temperature at a minimum of 100 degree F and shall note exceed 116 degree F	3/29/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TKQuyas1 TITLE DIRECTOR (X6) DATE 4/24/26

STATE FORM 6899 ZNP411 If continuation sheet 1 of 10

Reviewed and Acknowledged 05/01/26 KC

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C 105	Continued From page 1 revealed the current census was 3. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety issues memo revealed: -A hot water temperature of 116.6 degrees Fahrenheit (°F) can cause first degree burns within 20 minutes and second degree burns within 45 minutes. (A first-degree burn is a superficial burn affecting the outer layer of skin. A second-degree burn affects both the outer and second layer of skin and may cause blistering.) -A hot water temperature of 118.4°F can cause first degree burns within 15 minutes and second degree burns within 20 minutes. -A hot water temperature of 120°F can cause first degree burns within 8 minutes and second degree burns within 10 minutes. Observation of the hot water temperature in the sink of the front bathroom on 03/27/26 at 8:23am revealed the hot water temperature fluctuated between 116.2°F and 119.8°F. A second observation of the hot water temperature in the sink in the front bathroom on 03/27/26 at 8:37am revealed the hot water temperature was 120°F. A third observation of the hot water temperature in the sink in the front bathroom on 03/27/26 at 1:24pm revealed the hot water temperature was 119.8°F. Observation of the front bathroom on 03/27/26 at 1:24pm revealed there was a caution sign posted stating the water was hot and that the sink was not to be used. Interview with Resident #2 on 3/27/26 at 1:30pm	C 105	Facility Shall check hot water temperature 2 times a week and keep a water temperature log.	

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C 105	Continued From page 2	C 105		

revealed:
-He liked living at the facility.
-Staff took good care of him.
-He showered himself but the Supervisor-in-Charge (SIC) turned the water on for him to shower.
-He turned the water on in the sink for himself.
-The water was never too hot; the water was warm to him.
-He had never been burned by the hot water.

Interview with Resident #1 on 03/27/26 at 3:02pm revealed:
-He had been living at the facility for 2.5 years.
-Residing at the facility was okay.
-He used the second bathroom in the facility most of the time.
-He showered himself and turned the water on for himself in the shower and the sink.
-When he used the front bathroom, he turned the water on for himself.
-The water had never been too hot, and he had not been burned by the hot water.

Interview with Resident #3 on 03/27/26 at 4:33pm revealed:
-He was unsure how long he had been living at the facility.
-He showered himself and turned the water on for himself.
-He only used the second bathroom, which was right by his room.
-The water felt nice and he had never been burned by the hot water.

Interview with the SIC on 03/27/26 at 4:13pm revealed:
-She had no concerns with the temperature of the hot water.
-She turned the water on for the residents when it

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C 105	Continued From page 3 was time for them to shower. -She adjusted the water temperature and tested it with her hand. -She had the residents to test the water with their hands before getting in the shower. -Resident turned the water on in the sink for themselves. -A local maintenance company came and adjusted the hot water temperature because the water was a "little too hot" in the front bathroom sink but she could not remember when that occurred. -Someone from the local Department of Social Services (DSS) noticed that the water in the front bathroom sink was a little too hot. -The local maintenance company owner did a lot of work around the facility so he may not remember adjusting the hot water temperature. -She was unsure if there was documentation showing that the local maintenance company came out to adjust the hot water temperature. -None of the residents complained about the water being too hot. -None of the residents had been burned by the hot water. Interview of the Administrator on 03/27/26 at 8:30am, 1:24pm and 4:15pm revealed: -She checked the water temperatures every other week. -The front bathroom sink fluctuated in hot water temperature. -She did not know how to adjust the hot water temperature. -She thought the hot water temperature was supposed to be 116°F to 120°F. -She called a maintenance company 1 to 2 months ago and had the hot water temperature adjusted. -She had no receipts to show when the hot water	C 105		

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C 105	Continued From page 4 temperatures were adjusted. -She kept a log of the hot water temperatures after being told to do so by the local DSS (date unknown). -She kept the logs on the wall in each bathroom. -She removed the logs when the facility was being painted about 3 months ago and never put the logs back up. -She had not recorded water temperatures in 3 months. -The previous temperature logs tore when she took them down due to moisture from the bathroom. -None of the residents complained about the water being too hot. -None of the residents had been burned by the water. -Staff assisted the residents by turning the water on for them. -Residents were not allowed to use the front bathroom and had been redirected to use the second bathroom until the local maintenance company adjusted the water temperatures on tomorrow, 03/28/26. -She was concerned residents would get burned by the hot water in the front bathroom sink. Telephone interview with the owner of the local maintenance company on 03/27/26 at 1:58pm revealed: -He had been to the facility to do things such as put up smoke detectors, work on the back fence, and unclog a toilet. -He never checked the hot water temperature or did any work on the sinks at the facility. -His last time at the facility was a couple of months ago. -He was not aware that the hot water temperature was too high in the front bathroom sink. -The water heater was located under the home,	C 105		

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C 105	Continued From page 5 under the front bathroom sink. -The location of the water heater in relation to the sink could be causing the water to be too hot because the water came directly from the water heater to the sink; the water had to travel further to get to the other fixtures. -He would visit the home tomorrow, 03/28/26, to adjust the hot water temperature.	C 105		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the electronic	C 342		

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C 342	Continued From page 6 medication administration records (eMAR) were complete and accurate for 1 of 3 sampled residents (#1) related to a medication used to lower blood sugar levels. The findings are: Review of Resident #1's current FL-2 dated 01/07/26 revealed diagnoses included diabetes, hypertension, hyperlipidemia, and schizophrenia. Review of Resident #1's Resident Register revealed he was admitted on 06/30/22. Review of Resident #1's Primary Care Physician's (PCP) order dated 03/04/26 revealed there was an order to decrease Insulin Glargine 100 pen subcutaneously at night from 10 units to 8 units. (Insulin Glargine is used to treat diabetes.) Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Insulin Glargine 100 pen, inject 10 units subcutaneously in the evening, scheduled to be administered at 8:00pm. -There was documentation Insulin Glargine 10 units was administered daily from 03/01/26 to 03/26/26 at 8:00pm. Observation of Resident #1's medications on hand on 03/27/26 at 10:20am revealed there was 1 pen on the cart with the box labeled for Insulin Glargine 100 pen, inject 10 units subcutaneously in the evening. Interview with Resident #1 on 03/27/26 at 3:02pm revealed: -He had been living at the facility for 2.5 years. -He took insulin, but it was hard to remember the	C 342	Facility shall follow up with Primary Care Physician and Pharmacy to ensure New orders are sent and received by Pharmacy without delay. (2) Supervisor shall ensure that changes	

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C 342	Continued From page 7 name of the medication. -Staff administered his medication. -He was unsure of the name of his insulin because his medication had changed. -He was unsure what his insulin dose was. Interview with the Supervisor-in-Charge (SIC) on 03/27/26 at 11:30am revealed: -She and the Administrator were responsible for administering medication to Resident #1. -When the PCP wrote a new order, he sent the order to the pharmacy. -The facility sent the note that the PCP wrote with his signature on it to the pharmacy. -Resident #1 was administered 8 units of Insulin Glargine at night. -Resident #1 was administered 8 units of Insulin Glargine since the PCP changed the order on 03/04/26. -The Administrator was responsible for making changes to the eMAR until the pharmacy sent an updated eMAR. -She spoke with the pharmacy last week about the change needed on the eMAR regarding Resident #1's Insulin Glargine. -Pharmacy staff told her they would send an updated eMAR but did not say when they would send the updated eMAR. Interview with a pharmacist at the facility's contracted pharmacy on 03/27/26 at 10:53am revealed: -Resident #1 had an order for Insulin Glargine, 10 units every evening. -The pharmacy received the documentation from the facility that was provided by Resident #1's primary care provider (PCP) to decrease the Insulin Glargine from 10 units to 8 units but the pharmacy could not accept the documentation as an order.	C 342	Cont: are made on the medication administration Record (M.A.R) where necessary until pharmacy sent an updated (M.A.R.)	3/28/26

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C 342	Continued From page 8 -The PCP needed to send an order to the pharmacy for the order to be changed on Resident #1's eMAR and the medication label. -He spoke with someone at the facility and explained that the PCP needed to send an order, but he was unsure of the date of the call and who he spoke with at the facility. -The facility could administer 8 units of Insulin Glargine to Resident #1 because they had documentation from the PCP to do. -The facility had to administer the medication based on the information provided to them by the PCP. -Pharmacy added orders to the eMAR after receiving the orders from the provider the pharmacy could not change the order in the system without an order to justify the change. -The PCP did not send a new order for the Insulin Glargine, 8 units every evening. -If changes were needed to be made to the eMAR, the facility could make the change until the pharmacy sent new eMARs the next month. -The pharmacy sent 2 extra pages to the eMAR each month so the facility can make any changes needed to include dose changes and new medications. Telephone Interview with a patient care coordinator at Resident #1's PCP office on 03/27/26 at 11:19am revealed: -Resident #1's PCP was not in the office today, 03/27/26. -There was a note written in Resident #1's record stating the Insulin Glargine was to be decreased from 10 units to 8 units at night. -An order was supposed to be sent to the pharmacy by the PCP. -There was no documentation showing that the order had been uploaded to the pharmacy by the PCP.	C 342		

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C 342	Continued From page 9 Interview with the Administrator on 03/27/26 at 10:28am revealed: -The PCP visited Resident #1 at the facility. -When the PCP wrote a new order, he gave the facility a copy and he sent a copy to the pharmacy. -The pharmacy sent the medication based on the orders the PCP sent to them. -The pharmacy added medications to the eMAR. -The pharmacy did not change the Insulin Glargine dose on the eMAR. -She was responsible for changing the dose of the Insulin Glargine on the eMAR. -She did not change the dose of the Insulin Glargine on the eMAR because she waiting on the pharmacy to make the change. -The PCP wrote an order to decrease Resident #1's Insulin Glargine 10 units to 8 units. -Both she and the SIC administered medication to Resident #1. -Resident #1 was not administered 10 units of Insulin Glargine. -The resident was administered 8 units of Insulin Glargine based on the PCP's order on 03/04/26. -She should have crossed out the Insulin Glargine 10 units and added the new order to another page. Attempted telephone interview with Resident #1's responsible party on 03/27/26 at 11:28am was unsuccessful.	C 342		