STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 02/18/20-02/19/20.	{D 000}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate care and services for 2 of 9 sampled residents (Resident #1 and #9) related to not responding to a hand bell for a legally blind resident who needed assistance (Resident #9) and for a resident that did not have a hand bell that felt unsafe in his room without a way to get the attention of facility staff when his blood sugar dropped (Resident #1). The findings are: 1. Review of Resident #1's current FL2 dated 02/05/20 revealed diagnoses included diabetes, insomnia, anxiety, asthma, and chronic obstructive pulmonary disease. Interview with Resident #1 on 02/19/20 at 10:30am revealed: -He had diabetes and his blood glucose level would "drop low" sometimes.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 1 -He was recently admitted to the hospital on three separate occasions because his blood glucose level had dropped too low while he was sleeping. -He had a "hard time getting help" from the staff at times. -He had no way to call staff for assistance when he needed help and could not walk to the nurse's station, so he had to yell from his room. -He did not have a call bell or other signaling device in his room to get the attention of the facility staff. -He was able to feel when his blood glucose level would drop when he was awake because he would feel weak and dizzy. -He had to walk to the nurse's station to get juice to drink when his blood glucose level was low. -He would like a hand bell to use when he needed staff's assistance and was too weak or dizzy to walk up the hallway. -He was "just scared my sugar will drop and I won't be able to get help and I might fall into a diabetic coma". -He had to get help from another resident once because he had fallen in his room and was yelling for help and staff could not hear him. Interview with a medication aide (MA) on 02/18/20 at 9:10am revealed: -Resident #1 had several recent trips to the emergency room (ER) because of low blood sugars. -Resident #1 was found on the floor by a personal care aide (PCA) during rounds last month (01/06/20) and was sent to the ER. -Resident #1 was able to yell for help if he needed assistance or he would come down to the medication cart to find someone. Interview with a MA on 02/19/20 at 8:45am revealed:	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 2	{D 338}		

-The PCAs were supposed to check on the residents every 2 hours but the checks were not documented.
-A PCA found Resident #1 on the floor in his room on 01/06/20 when he was sent to the hospital.
-The PCA came and got her to check Resident #1's fingerstick blood sugar (FSBS).
-She called 911 for an ambulance to come pick up Resident #1.

Interview with a PCA on 02/19/20 at 9:40am revealed:
-She found Resident #1 on the floor by his bed on 01/06/20.
-Resident #1 was shaking and was bleeding from his arm.
-She did not know how long Resident #1 had been in the floor before she found him.
-She thought it had been at least 45 minutes since she had completed her last rounds.

Review of Resident #1's December 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry to check blood sugar three times daily before meals at 6:00am, 10:30am, and 3:30pm.
-Resident #1's FSBS was documented as <100 for 15 out of 83 opportunities from 12/01/19 to 12/31/19 including a reading of 56 at 3:30pm on 12/18/19 and 52 at 3:30pm on 12/31/19
-Resident #1 was "sent to the ER due to bottomed blood sugar and hitting head/bleeding on arms" on 12/28/19.
-Resident #1's FSBS was documented as 69 on 12/28/19 at 10:30am.

Review of Resident #1's January 2020 eMAR revealed:
-There was a computer-generated entry to check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 3	{D 338}		

blood sugar three times daily before meals at 6:00am, 10:30am, and 3:30pm.
-Resident #1's FSBS was documented as <100 for 4 out of 24 opportunities at 10:30am, including a reading of 65 on 01/04/20 and 59 on 01/06/20
-Resident #1's FSBS was documented as <100 for 7 out of 25 opportunities at 3:30pm, including a reading of 75 on 01/01/20, 61 on 01/16/20, 79 on 01/18/20, and 79 on 01/21/20.
-Resident #1 was "sent to the ER due to BS dropped to 35" from 01/06/20-01/07/20.
-Resident #1 was "sent to hospital due to sugar drop" from 01/22/20-01/27/20.

Review of Resident #1's February 2020 eMAR revealed:
-There was a computer-generated entry to check blood sugar three times daily before meals at 6:00am, 10:30am, and 3:30pm.
-Resident #1's FSBS was documented as 71 on 02/05/20 at 3:30pm, 79 on 02/17/20 at 3:30pm, and 87 at 10:30am on 02/18/20.

Observation of the medication pass on 02/19/20 at 10:00am revealed:
-Resident #1 approached the medication cart and stated that he needed his FSBS to be rechecked.
-Resident #1 was pale and shaky.
-The MA checked Resident #1's FSBS and it was 80.

Interview with Resident #1 on 02/19/20 at 10:00am revealed:
-Resident #1's FSBS was 59 about 15 minutes prior to getting it rechecked.
-He was in his room when he started to feel lightheaded.
-He had to walk down the hall and find the MA to have his FSBS checked.
-The MA had given him some orange juice to help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 4	{D 338}		

bring his sugar up.
-He needed to have a way to notify the facility staff when he thought his FSBS was low.
-He was afraid he would need someone (facility staff) and not be able to yell or walk down the hall looking for someone.

Review of Resident #1's Hospital Discharge summary dated 01/22/20 revealed:
-Resident #1 presented to the ER with a FSBS of 35, had a low-grade fever, elevated white blood cells, evidence of a urinary tract infection, and abnormal heart enzymes.
-Resident #1 was diaphoretic (increased sweating), clammy, and confused.

Interview with the Supervisor on 02/19/20 at 5:17pm revealed:
-She did not think Resident #1 needed a hand bell because he was ambulatory.
-If the residents could ambulate on their own then they were not given a hand bell.
-Resident #1 had only recently started having trouble with his FSBS dropping.
-Resident #1 was able to walk down the hall to get help if his FSBS was low.
-She was responsible for making him an appointment with an Endocrinologist on 02/13/20.
-She spent the night in the facility and checked on Resident #1 multiple times throughout the night.
-The third shift staff would come get her if Resident #1 had problems with his FSBS.

Interview with the Resident Care Coordinator (RCC) on 02/19/20 at 4:34pm revealed:
-She thought only the residents that were wheelchair bound needed a hand bell.
-She worked on 01/22/20 but did not remember what happened to Resident #1.
-The PCAs should be checking on the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 5 every hour to make sure they did not need anything and to make sure they were okay. Interview with the Business Office Manager (BOM) on 02/19/20 at 4:46pm revealed: -She or the Supervisor completed individual assessments on all the residents based on falls risk. -All residents that were identified as an increased falls risk were given a hand bell to keep in their room. -Resident #1 was ambulatory and she did not think he needed a hand bell. Interview with the Administrator on 02/19/20 at 5:42pm revealed: -The BOM and Supervisor were responsible for the day to day operations of the facility. -All residents should not have a hand bell. -There would be "chaos" in the building if every resident had a hand bell. -The BOM and the Supervisor were responsible for completing an assessment to determine which residents were ambulatory. -The BOM and the Supervisor were responsible for talking to the physician to get orders for hand bells. -If a resident did not need a hand bell then they would get an order stating the resident did not need a hand bell. Attempted telephone interview with Resident #1's primary care provider on 02/19/20 at 12:20pm was unsuccessful. 2. Review of Resident #9's current FL2 dated 01/13/20 revealed diagnoses included hypertension, hyperlipidemia, and mood disorder. Review of Resident #9's Care Plan dated	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 6 01/13/20 revealed: -Resident #9 was legally blind. -Resident #9 was totally dependent and required assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Interview with Resident #9 on 02/18/20 at 8:55am revealed: -She was legally blind and could only see shadows. -She was told she needed to have assistance to walk to the dining room. -She was given a hand bell to signal the staff that she needed assistance. -She had rung the bell in her room and from the bathroom inside her room, but no staff came to check on her. -She never used the hand bell because the staff never responded to her or could not hear the hand bell. -If the staff did respond to the hand bell then they could never find which resident had rang a hand bell. Second interview with Resident #9 on 02/19/20 at 4:25pm revealed: -She was "very concerned" that no one responded to her ringing her hand bell. -She was afraid she would fall in the bathroom and no one would come to help her. -She must rely on her roommate to send text messages to the Supervisor when she needed assistance. -She had to open her door and yell for help to get the attention of the facility staff. -She had given up using the hand bell and would just do things on her own like going to the dining room. Observation of Resident #9 on 02/19/20 at	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 7 4:25pm revealed she exited her room alone and walked down the hall towards the dining room holding the railing attached to the wall. Interview with a Personal Care Aide (PCA) on 02/19/20 at 4:10pm revealed: -Resident #9 would stand at her door and yell if she needed anything. -Resident #9 needed assistance going to the dining room and with showers. -She would respond to hand bells when she heard them. -She could hear the hand bells in the hallway. Interview with a second shift MA on 02/19/20 at 4:00pm revealed: -Resident #9 would yell if she needed anything. -She could hear the hand bells in the hallway when residents would ring the bells. -A MA, PCA, or staff were responsible for responding to the hand bells. Interview with the Resident Care Coordinator (RCC) on 02/19/20 at 4:34pm revealed: -Resident #9 had a hand bell in her room. -The PCAs should be checking on the residents every hour to make sure they did not need anything and to make sure they were okay. Interview with the Supervisor on 02/19/20 at 5:17pm revealed Resident #9's roommate would send her text messages if Resident #9 needed assistance. Interview with the Administrator on 02/19/20 at 5:42pm revealed: -The Business Office Manager (BOM) and the Supervisor was responsible for the day to day operations of the facility. -The BOM and the Supervisor were responsible	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D 338}	Continued From page 8 for making sure the staff were monitoring and assisting the residents as needed. _____ Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 9 residents did not receive adequate care and services related to Resident #1 who was afraid he might experience a diabetic coma without a signaling device to notify the staff his blood sugar was low if he was not able to yell or walk the halls to find someone for assistance after he had been sent to the hospital three times (12/28/19, 01/06/20, and 01/22/20) with fingerstick blood sugars (FSBS) reported as low as 29. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection on 02/26/20 in accordance with G.S. 131D-34 for this violation.	{D 338}		
D 441	10A NCAC 13F .1208 Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred. This Rule is not met as evidenced by: Based on interviews and record review, the	D 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
D 441	Continued From page 9	D 441		

facility failed to ensure a written report was submitted to the Division of Health Service Regulation (DHSR) regarding the unexpected death of one resident (Resident # 3).

The findings are:

Review of Resident #3's FL2 dated 06/21/19 revealed diagnoses included coronary artery bypass, congestive heart failure, hypertension, angina, history of cerebrovascular accident, seizure disorder, diabetes mellitus, dementia with delusions, and rectal cancer.

Review of Resident #3's Incident Report dated 01/04/20 revealed:
-The resident was in his room changing his pants.
-The resident yelled for help.
-Staff went to the resident room and the resident told staff he could not breathe.
-The resident told staff he wanted to go to the hospital.
-Staff notified 911.
-The resident became unable to talk at the time emergency medical services (EMS) arrived.
-EMS personnel and facility staff put the resident on the floor and began cardiopulmonary resuscitation (CPR).
-CPR was performed for "25 to 30 minutes" until the resident was pronounced deceased.
-EMS transported the resident to a local hospital.

Review of Resident #3's Report of Death to DHHS form dated 01/04/20 revealed:
-The event related to or resulting in the resident's death was documented as an accident.
-The resident was documented as not having been restrained within seven days of the death.
-There was a stamp on the document which indicated "Faxed On Jan 04 2020."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
D 441	Continued From page 10 -A fax number handwritten on the bottom of the form was for the local County Department of Social Services (DSS) Review of a fax confirmation dated 01/04/20 revealed: -Resident #3's Report of Death to DHHS dated 01/04/20 had been faxed to the local County DSS on 01/04/20 at 6:12pm. -The fax transmission was successful. Review of the facility's history for death reporting on 02/19/20 revealed the death occurrence on 01/04/20 had not been reported to DHSR. Interview with the Supervisor on 02/19/20 at 1:00pm revealed: -She faxed Resident #3's death report to the local County DSS on 01/04/20. -She did not know she was supposed to fax the report to the DHSR Complaint Intake Unit. -She was not familiar with the new death reporting form. -She had "always" faxed death reports to DSS. Interview with the Administrator on 02/19/20 at 5:45pm revealed: -The Supervisor, Resident Care Coordinator, or the Business Office Manager could report a resident death. -He would have expected the staff to send the death report to the local County DSS and to the DHSR Complaint Intake Unit.	D 441		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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
{D912}	Continued From page 11 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents' rights. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate care and services for 2 of 9 sampled residents (Resident #1 and #9) related to not responding to a hand bell for a legally blind resident who needed assistance (Resident #9) and for a resident that did not have a hand bell that felt unsafe in his room without a way to get the attention of facility staff when his blood sugar dropped (Resident #1). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Unabated Type B Violation)].	{D912}		