Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING HAL043003 10/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HWY 301 NORTH** JOHNSON BETTER CARE FACILITY, INC. **DUNN, NC 28335** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 Report of a Construction Section Biennial Survey by Suzanna Fay conducted on October 17, 2018. Records indicate this facility was first licensed on July 24, 1979. The facility is currently licensed for 50 Beds. Therefore the facility was surveyed for conformance with the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds and applicable portions of the 1967 Edition of the North Carolina Building Code(s), Institutional Occupancy and the 1977 Rules for Licensing of Adult Care Homes of Seven or More Beds in effect at the time of initial licensure. C 160 C 160 Outside Premises-Clean, Safe SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL **ENVIRONMENT** (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; This Rule is not met as evidenced by: 1. Observations revealed that the outside grounds were not maintained in a clean and safe condition. Findings on October 17, 2018: a. The exterior face of the firewall at Room 16 has a large crack at the face of the exterior wall that has been filled with foam caulk. The wing wall has a large joint crack and the wall has shifted about 2". Interview with staff revealed that they were investigating the issue.

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED			
		HAL043003		B. WING		10/1	7/2018
	PROVIDER OR SUPPLIER	CILITY, INC.	STREET AD HWY 301 DUNN, NO	NORTH	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 164	Continued From pa	ge 1		C 164			
C 164	4 Housekeeping and Furnishings-Clean, Repaired			C 164			
	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of (e) This Rule shall facilities.	es shall: ings, and floors o n and in good rep c unpleasant odor elean and in good apply to new and et as evidenced b vealed that the fu	r floor pair; rs; repair; existing				
	Findings on Octobe a. Room 6 - the bu the drawers are dar revealed that they a the cabinetry.	ilt-in cabinets are naged. Interview	with staff				
	2. Observations re- kept clean and in go		oors were not				
	Findings on Octobe a. Room 6 - the flo red rust marks undo observation reveale throughout the facil dirty.	ors are stained a er the furniture. F ed that the white t	urther ile floors				
	3. Observations receilings were not ke						
	Findings on Octobe a. Room 11 - the co		I from a				

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	IT OF DEFICIENCIES	(X1) PROVIDER/S		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICAT	FION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL0430	003	B. WING		10/1	7/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY S	STATE, ZIP CODE		
			HWY 301		<u>-, -</u>		
JOHNSO	N BETTER CARE FA	CILITY, INC.	DUNN, NO	_			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	•	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECE	DED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING I	NFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
C 164	Continued From pa	ge 2		C 164			
	previous leak.						
	b. Utility Closet - th	ere is a area c	of damaged				
	ceiling approximate						
	sink. The damage	is water dama	ge from the				
	storm.	a nanaarn finis	م اماده ماده ما				
	c. Living Room - th						
	and splitting open along the corridor wall. d. Kitchen - the roof leaked during the recent storm. The ceiling is sagging and the light fixtures are no longer secure. There are black mold spots around the light fixtures and mechanical grilles. e. Dining Room - the ceiling suffered damage from roof leaks during the recent storm. A						
	section in the back	•					
	patched. There are						
	and the popcorn fin						
	the dining area.						
	f. Dining Room - th						
	running down the wall throughout the dining area. g. Outside Laundry - a large section of the ceiling						
	collapsed during the						
	under repair and currently has a large opening in the ceiling.						
	J						
C 166	Housekeeping-Main	ntained Free o	f Hazards	C 166			
	SECTION .0300 - F	PHYSICAL PLA	ANT				
	10A NCAC 13F .0306 HOUSEKEEPING AND						
	FURNISHINGS						
	(a) Adult care home						
	(5) be maintained i						
	orderly manner, fre hazards;	e oi ali obstruc	มเบทร สทีน				
	(e) This Rule shall	apply to new a	and existing				
	facilities.		a onlouing				
	This Rule is not met as evidenced by:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL043003	B. WING		10/1	17/2018
	PROVIDER OR SUPPLIER	CILITY, INC. HWY 301		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 166	1. Observations remaintained free of a Findings on Octobe a. North Hall exit opened due to wear base of the door to during the recent stat the time of surve b. The handrail out One of the screws inc. South Hall exit walk outside the exegress path. Intervibeds were moved of being repaired from that are improperly to the occupants of Findings on Octobera. Five oxygen both the hallway outside removed during the b. Room 10 - one of the screw in the second s	vealed that the facility was not all obstructions and hazards. In 17, 2018: It exit door could not be therseal tape applied to the keep water from coming in orm. The tape was removed by. Is side of Room 3 is not secure. In the bracket is loose. It wo bed frames were on the it door partially blocking the iew with staff revealed that the but of a bedroom that was a storm damage. I wation the facility was not m hazards. Oxygen bottles stored may present a danger the facility. In 17, 2018: I les were found unsecured in of Room 9. These were survey. Insecured oxygen bottle was m. The bottle was removed				
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plu	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and	C 189			

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		HAL043003	B. WING		10/1	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JOHNSC	N BETTER CARE FA	CILITY, INC. HWY 301				
		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 4	C 189			
	facilities with the ex	apply to new and existing ception of Paragraph (e) ly to existing facilities.				
	This Rule is not met as evidenced by: 1. Observations revealed that the electrical equipment was not maintained in a safe and operating condition. Findings on October 17, 2018: a. The exterior GFCI outlet to the left of the front porch is missing its protective, weatherproof cover. b. Staff Lounge - the electrical box by the exterior door is missing a cover plate. c. Room 16 Toilet - both of the light switches are broken off. 2. Based on observation there is a failure to maintain the building's fire safety systems in a safe condition. Holes or gaps at penetrations through fire resistant rated ceilings could allow fire and smoke to spread beyond the area of origin.					
	station has a gap b rated ceiling assem b. Room 6 - there i	ector in front of the nurses' etween the detector and the				
	maintain the facility safe operating cond compartment could doors do not compl	vation there is a failure to 's fire safety equipment in a dition. Occupants in the smoke be exposed to smoke or fire if etely close and latch to help smoke or fire to the area of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		HAL043003	B. WING		10/	17/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JOHNSC	N BETTER CARE FA	CILITY, INC. HWY 301 DUNN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
C 189	and does not close b. Room 3 - the laid door will not latch with the common trelease so the colosed. 4. Observations resequipment was not operating condition. Findings on Octoberation as Room 5 Toilet - 5. Based on obsermaintain electrical equipment in safe of effect occupants of exits were not illuminate where the condition. The emergency not illuminate where the condition of the faction o	er 17, 2018: door is dragging on the frame and latch. tich does not engage and the when closed. atch is jammed and the does door does not latch when evealed that the plumbing maintained in a safe and er 17, 2018: the toilet seat is missing. evation the facility did not emergency/safety lighting operating condition. This could if the facility if egress paths and inated during a power outage. er 17, 2018: light outside of Room 19 did in tested. light in the Dining Room did in tested. vation the facility's fire safety aintained in operating or maintain fire safety ating condition could effect incility if the equipment did not the case of a fire or other				
	Findings on October 17, 2018: a. Dining Room - the smoke detector is dangling					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			
		HAL043003	B. WING		10/	17/2018
	PROVIDER OR SUPPLIER	CILITY INC	ADDRESS, CITY, S' 01 NORTH NC 28335	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 189	from its wires. 7. Observations re equipment is not moperating condition Findings on Octobera. Kitchen - the Reaccumulation of dub. Laundry - all threexhaust were missis. Pests can enter the ducts or pests could creating a fire haza. 8. Based on observation has not been inspermaintained in a saff Occupants of the fasafety equipment in not operate when not op	vealed that the mechanical aintained in a safe and er 17, 2018: turn Air grille has a heavy st. ee of the exterior dryer ng the backdraft dampers. elaundry area through the dibuild nests in the ducts rd. vation fire safety equipment cted to assure it has been e and operable condition. acility could be effected if fire a the smoke compartment die eded to provide fire er 17, 2018: the fire extinguisher has not e 2016. vation there is a failure to 's fire safety equipment in a dition. The occupants in the not could be effected if the fire s do not completely close are e spread of smoke and/or fire. er 17, 2018: the Men's Hall did not close was activated. They did	e e e e			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING _ HAL043003 10/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HWY 301 NORTH** JOHNSON BETTER CARE FACILITY, INC. **DUNN, NC 28335** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 189 Continued From page 7 C 189 between the door panels when the doors are closed which will allow for the passage of fire and smoke through the doors. c. Fire doors at Women's Hall - there is a 1/2" gap between the door panels when the doors are closed which will allow for the passage of fire and smoke through the doors. C 199 Exhaust Ventilation C 199 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Observations revealed that the facility did not provide working exhaust ventilation in required areas. Findings on October 17, 2018: a. Room 5 Toilet - the exhaust fan is not working. b. Men's Staff Toilet - the exhaust fan is not c. The exhaust fans typically are in need of cleaning. A heavy accumulation of dust can cloq

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		HAL043003	B. WING		10/	17/2018
	PROVIDER OR SUPPLIER ON BETTER CARE FA	HWY 301	NORTH	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
C 199	the vent and prever the required rate. d. Room 16 Toilet working. e. Utility closet - the	ge 8 Int the exhaust from pulling at the exhaust fan is not working accumulation of dust.	C 199			

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