STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED	
		HAL043003		B. WING		02/1	3/2019
NAME OF F	PROVIDER OR SUPPLIER	TIALOTOGO	CTDEET AD	DDESS CITY (	CTATE ZID CODE	02/1	3/2013
			HWY 301		STATE, ZIP CODE		
JOHNSO	N BETTER CARE FAC	CILITY, INC.	DUNN, NO	_			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
{C 000}	Initial Comments			{C 000}			
	Report of a Biennia Survey by Suzanna 13, 2019.						
	There are deficienc Construction Surve						
{C 164}	Housekeeping and	Furnishings-Clean	, Repaired	{C 164}			
	SECTION .0300 - F 10A NCAC 13F .030 FURNISHINGS (a) Adult care home (1) have walls, ceili coverings kept clea (2) have no chronic (3) have furniture of (e) This Rule shall facilities.	es shall: ings, and floors or n and in good repa c unpleasant odors lean and in good re	floor air; ;; epair;				
	This Rule is not me 3. Observations re- ceilings were not ke	vealed that the wal	ls and				
	Findings on Februa g. Outside Laundry collapsed during the repair has not been was extensive damand this area is awa work in this area wa other rooms.	y - a large section of e recent storm. The completed because age to the facilities ay from the Reside	e ceiling se there ' ceilings nts. The				
{C 189}	Building Equipment	Maintained Safe,	Operating	{C 189}			
	SECTION .0300 - F 10A NCAC 13F .03						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
		HAL043003	B. WING			R <b>13/2019</b>	
	PROVIDER OR SUPPLIER  ON BETTER CARE FA	CILITY, INC. HWY 3	ADDRESS, CITY, S 01 NORTH NC 28335	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{C 189}	REQUIREMENTS  (a) The building ar mechanical, and ploare home shall be operating condition  (k) This Rule shall facilities with the exwhich shall not app  This Rule is not made and the shall not app  This Rule is not made and place and the shall not app  This Rule is not made and place	and all fire safety, electrical, sumbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ly to existing facilities.  Let as evidenced by: Let as e	ke e if				

Division of Health Service Regulation

STATE FORM 5699 JJFG22 If continuation sheet 2 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
		HAL043003	B. WING		02/1	₹ 3/2019
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  HWY 301 NORTH DUNN, NC 28335						
(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)	ILD BE	(X5) COMPLETE DATE
{C 189}	closed which will all smoke through the replace the doors. and the doors have will be installed as sc. Fire doors at Wogap between the doclosed which will all smoke through the replace the doors.	ow for the passage of fire and doors. They have decided to There was a long lead time just recently arrived. They soon as possible. Omen's Hall - there is a 1/2" for panels when the doors are ow for the passage of fire and doors. They have decided to There was a long lead time just recently arrived. They	{C 189}			
{C 199}	provided with exhautwo cubic feet per requirement does no before April 1, 1984 these specified spath (1) soiled linen store (2) soil utility rooms (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not appoint This Rule is not med 1. Observations reprovide working extra areas.	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This ot apply to facilities licensed with natural ventilation in ces: rage;  toilet rooms; closets; and apply to new and existing ception of Paragraph (e) by to existing facilities.  et as evidenced by: vealed that the facility did not naust ventilation in required	{C 199}			
	facilities with the ex which shall not app This Rule is not me 1. Observations re provide working exl	ception of Paragraph (e) ly to existing facilities. et as evidenced by: vealed that the facility did not naust ventilation in required				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		HAL043003	B. WING			R <b>13/2019</b>	
NAME OF PROVIDER OR SUPPLIER  JOHNSON BETTER CARE FACILITY, INC.  STREET ADDRESS, CITY, STATE, ZIP CODE  HWY 301 NORTH DUNN, NC 28335							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
{C 199}	d. Room 16 Toilet working. An attempthey have not beer fan is not working.	ge 3  - the exhaust fan is not by was made to repair the fan. In able to determine why the They have a contractor to investigate the problem.	{C 199}				

Division of Health Service Regulation STATE FORM