

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER JOHNSON BETTER CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C 000	Initial Comments Report of a Construction Section Biennial Survey b Ryan Meyer conducted on November 26, 2024. 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. Deficiencies were cited which will require a Plan of Correction.	C 000		
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (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. Based on observation the facility is not maintaining its plumbing system as necessary. Findings on November 26, 2024: a. The ice machine drain does not have the correct 2 inch air gap.	C 189		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER JOHNSON BETTER CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C 189	Continued From page 1 2. Based on observation, this facility has failed to maintain the fire safety components in a safe and operating condition. Findings on November 26, 2024: a. The fryer in the kitchen does not have proper coverage from the fire suppression system.	C 189		
C 199	Exhaust Ventilation 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. The facility is not keeping its exhaust fan in operable condition. Rule 10A NCAC 13F .0311 states exhaust fans are required to be in laundry rooms, restrooms, soiled linen, soiled utility, and housekeeping closets. Findings on November 26, 2024:: a. The exhaust fan in the men's restroom is not working.	C 199		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER JOHNSON BETTER CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 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	