STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 an annual and follow-up survey on June 2, 2026 through June 5, 2026.	D 000		
D 077	10A NCAC 13F .0306 (a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a sanitation report in accordance with one of the following: (A) a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times in facilities with 12 beds or less, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which are incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm; and (B) a North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation scores of 85 or above at all times in facilities with 13 beds or more. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions", 15A NCAC 18A .1300, can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 1 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to maintain a sanitation score of 85 or above at all times from the North Carolina Division of Environmental Health. The findings are: Observation of a North Carolina Environmental Health sanitation inspection certificate on 06/02/26 posted inside the facility at the entrance revealed: -The facility was inspected on January 8, 2026. -The sanitation score was 81. Interview with the Administrator on 06/02/26 at 8:38am revealed: -She was aware of the facility's "low" sanitation score of 81. -There were areas that still needed correcting that required the facility's Owner to fund, such as flooring. -She had not requested a revisit from the sanitation environmental health inspector. Review of the facility's current North Carolina Division of Environmental Health Inspection report dated 01/08/26 revealed: -The facility's sanitation score was 81. -There were 19 total deductions. -There were gaps present between floor panels in hallways and resident room floors. -Dust, residue and debris were observed on resident room floors, under beds, furniture, and along floor to wall junctures. -Metal door frames had peeling paint and rust,	D 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 2	D 077		

especially along floor and base areas.
-Storage rooms had residue on floors and debris under shelving.
-Floor coverings in resident rooms were worn and floor thresholds were missing.
-Ceilings in hallways, storage rooms, and resident rooms had peeling finishes, cracks, and unfinished sheetrock patching and were stained.
-Debris was present on walls in many resident rooms.
-Resident bathroom walls had dried residue, including fecal matter.
-Doors in resident rooms were damaged.
-Windows in resident rooms had peeling paint and visible gaps; the trim was dirty with dead bugs, dust and debris and some were missing trim.
-Blinds in resident rooms had dust and residue; some were damaged.
-Gaps to the outside were present around heating and air conditioner units.
-Moisture and water damage were present around heating and air conditioner units.
-A windowpane in a resident room was broken.
-Ceiling vents had heavy dust buildup and required cleaning.
-Toilet seat finishes were worn with fecal matter and urine present on toilets in shared and resident bathrooms.
-Multiple handsink faucets had corroded spigots with a faucet in a shared bathroom that was loose.
-Bathroom wall tile was missing, base tile damaged and the floors and walls were dirty with splatter and fecal matter.
-Standing water was present on resident bathroom floors.
-Reusable items were not labeled for individual residents as required.
-Bedpans, commodes, urinals, and emesis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 3	D 077		

basins were not consistently cleaned or disinfected between uses.
-Hand soap and paper towels were not available at the handsink in the hopper room.
-Environmental Protection Agency (EPA) registered disinfectants were not used according to manufacturer instructions.
-Staff were unaware of required disinfectant contact times.
-Staff reported using household all purpose cleaners for cleaning/disinfecting, but these products were not present on cleaning carts and were not used during cleaning.
-Multiple reusable resident cups were very dirty and had not been cleaned frequently enough.
-Sticky residue was present on water pitchers on medication carts.
-Debris and derelict equipment were present around the dumpster area.
-Trash and old equipment needed removal from the premises.
-Full sharps containers in the hopper room had not been disposed of when full.
-Medical waste was not removed frequently enough.
-Openings to the outside were present in resident rooms.
-Rodent fecal matter was found in resident rooms, on floors, and inside drawers.
-Openings lacked proper sealing, screening, or self closing mechanisms to prevent pest entry.
-Medication carts had residue present.
-Trays where cups were stored were dirty.
-Food, utensils, medications, and equipment on carts were not kept clean.
-Pillows and bed linens were stained and very worn.
-Bed frames were dirty and dusty.
-Wooden wall cabinetry interiors were worn.
-Water damage was present inside resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 4	D 077		

cabinets.
-Bedside furniture was worn and dirty.
-Furniture in resident rooms required cleaning.
-Cabinets in the hopper room required cleaning.
-Furniture in the sitting room was worn or torn and some was soiled.
-Resident room countertops were very dirty.
-Exposed wires and wire nuts were present in a resident room.
-Bed linens had holes, were worn and were not changed when dirty.
-Heavy residue and dirt were present on resident beds.
-A written procedure for responding to vomitus and fecal matter was not provided.
-Required supplies (gloves, personal protective equipment, disinfectant, disposable towels, coagulating agent) were not fully available as required.

Observation of a resident's room on 06/02/26 at 9:16am revealed:
-There were incontinence briefs on the floor near a bedside table.
-A resident was lying in bed with two incontinence briefs on and her bed was wet underneath her.

Observation of room 19 on 06/02/26 at 9:27am revealed there was clutter, and items strewn on the floor.

Observation of the facility's hallways on 06/03/26 at 7:25am revealed there were gaps in flooring at the double doors near the employee lounge, filled with dirt and debris.

Observation of the facility's hallways on 06/03/26 at 7:30am revealed there were gaps in the flooring in the areas by the men's and women's restrooms, filled with dirt and debris.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 5 Interview with the facility's housekeeper on 06/04/26 at 9:23am revealed: -There were certain things like the stuff in the bathrooms needed to be dusted off, making sure he wiped the rails, keeping the floors clean. -The maintenance work on the A/C units also needed to be done. -There were termites on the wood around the A/C units. -The Administrator gave him a list of tasks she wanted him to do each day. -He also listened to the residents and did whatever was requested. Second interview with the Administrator on 06/03/26 at 2:14pm revealed: -When the environmental health inspectors conducted the inspection on 01/08/26, they were informed that residents and staff were sick with COVID-19. -There were problems with floor and general cleanliness. -She had not felt the facility was ready for a re-inspection and had not requested an environmental health re-inspection. -She was told by the environmental health inspector that if a return inspection was conducted and the same problems and concerns were found, the demerit points would be doubled. -There was one housekeeper at the facility, and she was trying to stay on the housekeeper to keep resident rooms clean. Third interview with the Administrator on 06/04/26 at 5:02pm revealed: -The sanitation score will be redone, and she had already called the county to have the facility reassessed. -The facility staff had cleaned rooms, and all staff	D 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 077	Continued From page 6 were helping to clean rooms, the activity director would be helping with housekeeping, and she was talking to someone she wanted to hire this morning. [Refer to tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings] _____ The facility's failure to maintain a sanitation score above 85 from the North Carolina Division of Environmental Health was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/03/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/20/26.	D 077		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 7	D 079		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain the facility in a clean and orderly manner, free of all obstructions and hazards and provide a safe environment related to loose floor tiles, leaking toilets in a shared resident bathroom and in the men's bathroom on the men's hall near the employee lounge, loose or raised covers for the clean out drains in the hallways on both hallways, and doorways that had missing transition thresholds in several resident doorways.

The findings are:

Observation of the facility's hallways on 06/03/26 at 7:25am revealed there were gaps in flooring at the double doors near the employee lounge, filled with dirt and debris.

Observation of the facility's hallways on 06/03/26 at 7:30am revealed:
-There were gaps in the flooring in the areas by the men's and women's restrooms, filled with dirt and debris.
-The flooring was uneven.
-Pieces of the flooring were raised between the flooring tile/panels and created a tripping hazard for residents.

Review of the facility's current NC Division of Environmental Health Inspection report dated 01/08/26 revealed:
-One demerit was issued for flooring throughout the facility noting thresholds at hallway bathroom and room transitions were missing and gaps were present between floor panels in hallways and resident room floors and floor coverings worn in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 8	D 079		

resident rooms; dust, residue and debris were observed on resident room floors and had accumulated under beds, furniture, and along floor to wall.
-One and one-half demerits were issued for bathroom facilities not kept clean and in good repair noting fecal matter and urine on toilets in shared bathrooms on hallways and water standing on floor in a resident bathroom.

Observation of the hallway on the men's hall on 06/02/26 at 9:00am revealed:
-There was a male resident in a bariatric motorized wheelchair coming down the hallway at a quick rate from the nurse's station towards the end of the hall.
-He maneuvered his motorized wheelchair through the hallway and audible sounds were noted when his wheelchair went over the silver metal clean out drain covers as the weight of the chair compressed the drain covers.
-He slowed down at the second to the last door on the right-hand side of the hallway.
-He opened the door and proceeded into the room and then proceeded into the shared bathroom with his motorized wheelchair.
-The wheel casters scraped the door and door frame as he entered the bathroom.

Observation of a resident's shared bathroom on 06/04/26 at 10:00am revealed:
-The bathroom was shared between two residents in the adjoining bedrooms located on the right at the end of the men's hall.
-There were deep scrapes in the wooden bathroom door for the resident with the motorized wheelchair at the level of the wheel casters as well as scrapes into the door frame.
-The was a white porcelain sink and white porcelain toilet in the bathroom; there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 9	D 079		

shower, tub, or grab bar.
-The toilet had water leaking from the left side of the toilet near the sink.
-The water was absorbed with paper towels and flushed to reveal water leaking from the left side of the toilet near the sink.
-There was white silicone caulking around the base of the toilet which did not prevent the water from leaking from the toilet onto the floor.
-There were two sections of the floor tile raised from water damage.
-The water flowed towards the resident's bedroom located to the left of the sink.

Observation of the hallway on the women's hall on 06/03/26 at 2:33pm revealed:
-There were several floor tiles which were loose and raised in several places which created potential tripping hazards for residents.
-There were several silver-metal clean out drain covers noted in the hallway floors approximately every 50-100 feet.
-These silver metal clean out drain covers were raised approximately one quarter inch to one half inch from the flooring which created potential tripping hazards for residents.

Observation of resident's room 13 on 06/03/26 at 2:41pm revealed:
-Thresholds at hallway and room transitions were missing.
-There was a gap between floor panels in hallways and resident room floors.
-The gap caused the potential for tripping hazards for residents.

Observation of the hallway on the hall where the dining room door was located on 06/03/26 at 2:44pm revealed there was a silver metal clean out drain cover which was raised approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 10	D 079		

one quarter inch to one half inch from the flooring which created potential tripping hazards for residents.

Observation of the men's bathroom on the men's hallway near the employee lounge on 06/04/26 from 10:34am - 11:22am revealed:
-There were scrapes in the wooden bathroom door at the level of wheel casters from wheelchairs as well as scrapes into the door frame.
-The floors and walls were tiled.
-There was a white porcelain sink, a white porcelain toilet, and a white porcelain bathtub with shower in the bathroom.
-There was a grab bar on the tile wall across from the toilet and positioned partially behind the door.
-The toilet had water leaking from the right side of the toilet near the sink.
-The water was absorbed with paper towels and flushed to reveal water leaking from the right side of the toilet near the sink.
-There was no caulking noted around the base of the toilet.

Observations of room 8 on 06/03/26 at 9:03am revealed:
-The housekeeper was changing the bed linen and cleaning the room.
-There were two covered urinals on the bedside table next to the bed that were half full of a clear yellow liquid.

Observations of room 8 on 06/03/26 at 9:38am revealed:
-The two covered urinals half full of a clear yellow liquid remained on the bedside table.
-There was no staff observed in the room.

Observation of a laundry hamper on 06/04/26 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 11 10:36am revealed: -The hamper was positioned against the wall in front of the staff working station. -The hamper was overfilled with dirty linen preventing the lid from closing. Interview with the resident who resided in the second to the last room located on the right side at the end of the men's hall on 06/04/26 at 2:30pm revealed: -He used a motorized wheelchair to get around the facility. -He knew the toilet was fixed about a week or so ago. -The facility staff told him to use the men's bathroom/shower room at the end of the hall since it had more room to move his chair and the grab bar that was there. Interview with the female resident who resided in the last room located on the right side at the end of the men's hall on 06/04/26 at 10:30am revealed: -The toilet in her shared bathroom leaked again after only a week from being fixed. -The water would run out of the bathroom into her room, and it would puddle near her bed. -She was afraid of falling and that was why she kept the television on all night to provide light in case she had to get up she would see any water that may have puddled beside her bed. -The facility had replaced the toilet 2-3 times already and as soon as they fix it, the other resident with whom she shared the bathroom would go in there and hit the toilet with his motorized wheelchair and it would start leaking again. -One time the toilet had cracked from where his wheelchair had hit it. -She loved her room and had specifically asked	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 12	D 079		

for it since she liked the air conditioner that kept her room really cool especially at night so she could sleep.
-She worried that the facility may make her and the other resident with whom she shared the bathroom move to other rooms if she complained.
-The facility had moved him one time to a room across the hall (room 21) that was a larger private room with a private bathroom, but he broke that toilet too.

Telephone interview with a resident's family member on 06/03/26 at 11:18am revealed:
-They visited the facility several times per week.
-They were concerned about the condition of the floors in the facility due to the areas that were not level or raised.
-They observed a male resident in the motorized wheelchair zooming down the hallway and would run into door frames trying to get into areas like the dining room.
-That wheelchair looked very heavy, and they worried about him running into other residents as well as the damage the chair could cause to the doors and other areas of the facility.

Interview with a personal care aide (PCA) on 06/04/26 at 10:55am revealed:
-The resident with the motorized wheelchair was able to use the toilet without assistance.
-The toilet in his shared bathroom had to be replaced a couple of times because his motorized wheelchair would hit the toilet and cause it to leak.
-She had been told (but did not remember who) that he should use the men's bathroom up at the front of the hall near the nurse's station since the room was larger to accommodate him and his wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 13	D 079		

-The men's bathroom also had a grab bar for safety.
-When she saw something that needed to be repaired she would verbally tell the housekeeper who also helped with maintenance.

Interview with the facility's contracted plumber on 06/04/26 at 3:00pm revealed:
-He was made aware of the toilet leaking again yesterday on 06/03/26.
-He was here today, 06/04/26, to determine the exact problem and make the needed repairs.
-He had just replaced that same toilet last week.
-He thought there was not enough room in that bathroom to allow the resident with his motorized wheelchair into the bathroom without the wheelchair damaging the toilet.
-He told the Administrator this before.
-The Administrator had moved that resident to the private room across the hall (room 21) but that toilet had been broken too.

Interviews with the housekeeper on 06/03/26 at 9:03am and 06/04/26 at 3:10pm - 3:26pm revealed:
-He worked as the maintenance person, housekeeper, and personal care aide.
-The personal care aides are supposed to empty resident urinals.
-He saw the urinals in room 8 on 06/03/26 and meant to empty them when he made up the bed, but he forgot.
-He had noticed a smell of urine in room 8.
-He had replaced the toilets in the resident's shared bathroom at the end of the men's hall on the right side along with the toilet in room 21 after the resident with the motorized wheelchair had moved into it and broke that toilet.
-He thought the toilet in the men's bathroom across the hall from the employee's lounge had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 079	Continued From page 14 been fixed. -He was not aware that it had leaked again. Interview with the Administrator on 06/05/26 at 12:30pm revealed: -She was made aware each time that the toilet in the shared bathroom at the end of the men's hall needed to be repaired. -She did not know the exact dates but the facility had repaired or replaced the toilet three times already and this was the fourth. -Either the resident at the end of the men's hall told her or the housekeeping staff would let her know. -The male resident in the motorized wheelchair did not have enough room to use that bathroom due to the size of his chair. -She had moved him to room 21 which was a private room with it's own private bathroom but he broke that toilet in there too. -There was a little more room in that bathroom in room 21 than in that shared bathroom the plumber had replaced yesterday. -She explained to the male resident in the motorized wheelchair the need for him to use the men's bathroom up front to allow him more room to move his wheelchair in and out. -He would use the men's bathroom in the front of the facility but that was usually after he had broken the toilet in his shared bathroom. -She was not sure but thought this was the third time that toilet had to be replaced not counting the toilet in room 21 he had broken.	D 079		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 253	Continued From page 15 (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background;	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 253	Continued From page 16 (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to ensure an individualized care plan was completed annually and signed by the primary care provider (PCP) for 1 of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 04/01/26 revealed: -Diagnoses included type 2 diabetes, vitamin D	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 253	Continued From page 17	D 253		

deficiency, vascular disorder, hypertensive retinopathy, primary open-angle glaucoma, severe STA legal blindness, chronic atrial fibrillation, and repeated falls.
-There was no additional information provided in the section for patient information.

Review of Resident #3's Resident Register revealed an admission date of 11/08/23.

Review of Resident #3's record on 06/02/26 revealed:
-There was a care plan assessment completed on 03/06/25 and signed by the primary care provider (PCP) on 03/13/25.
-Resident #3 was assessed to have very limited vision, limited ability with ambulation, forgetful and needed reminders, and required limited assistance with eating, toileting, bathing, dressing, grooming, and transferring.
-There were no additional annual assessment and care plans available for review.

Observations of Resident #3 on 06/02/26 at 9:02am revealed:
-Resident #3 was walking in the hall close to the wall railing using a mobility cane.
-The resident was appropriately dressed and groomed.

Interview with Resident #3 on 06/02/26 at 9:02am revealed:
-He was blind.
-He wanted to be as independent as he could.
-He was learning how to get around in the facility using a [mobility] cane for guidance.
-Facility staff did everything for him.

Interview with a personal care aide (PCA) on 06/04/26 at 3:31pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 253	Continued From page 18 -She did not know anything about Resident #3's care plan and assessment. -She used an electronic activity of daily living form for guidance in providing care to Resident #3. Interview with the Administrator on 06/04/26 at 3:40pm revealed: -She had not been able to locate an updated care plan and assessment for Resident #3. -The Resident Care Coordinator (RCC) was responsible for managing the care plans which included completing the care plan assessment in preparation for the PCP review and signature and filing the completed care plan in the resident record. -The RCC position was currently vacant. -She did not have a process in place for her to review resident records.	D 253		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 19	D 270		

reviews, the facility failed to provide supervision according to the care plan and assessed needs for 1 of 5 sampled residents (#1) related to repeated falls and injury.

The findings are:

Review of the undated facility policy on accidents, incidents and deaths revealed:
-The facility will notify the county department of social services (DSS) of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.
-The facility will submit a written report that shall provide the following information: resident's name; name of staff who discovered the accident or incident; name of the person preparing the report; how, when and where the accident or incident occurred; nature of the injury; what was done for the resident, including any follow-up care; time of notification or attempts at notification of the resident's responsible person or contact person; signature of the administrator or administrator-in-charge.

Review of Resident #1's current FL-2 dated 12/17/25 revealed:
-Diagnoses included hypertension, diabetes, hyperlipidemia, anxiety disorder, Alzheimer's disease with late onset, hemiplegia and hemiparesis, cerebral infarction, urinary tract infection.
-She was semi-ambulatory with a walker.
-She was intermittently disoriented.
-She was incontinent of bladder.

Review of Resident #1's Resident Register revealed she was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 20 12/15/25. Review of Resident #1's care plan dated 12/17/25 revealed: -She required limited assistance with toileting. -She required supervision with ambulation. -She was totally dependent with bathing. -She required extensive assistance with dressing. -She required extensive assistance with grooming. -She required supervision with transferring. Observation of Resident #1 on 06/04/26 at 3:20pm revealed she was ambulating with a walker as her assistive device in the hallway and ambulated about 75 feet without staff assistance until staff arrived to help her sit down in the TV room. Review of Resident #1's electronic personal care log on 06/04/26 revealed Resident #1 was to receive limited assistance with toileting, transferring, bathing, and dressing from staff. Review of a primary care provider (PCP) order for Resident #1 dated 12/31/25 revealed physical therapy (PT) and occupational therapy (OT) were ordered for Resident #1. Review of Resident #1's record revealed PT was started on 01/13/26 and an OT evaluation took place on 01/14/26. Review of a facility accident/incident report for Resident #1 dated 02/26/26 revealed: -The incident occurred at 11:45am. -Resident #1 fell in her bathroom. -Resident #1's roommate alerted the staff. -Resident #1's roommate witnessed the fall. -Resident #1 was reportedly using her walker.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 21 -Resident #1 had a big knot on her head. -Resident #1 was sent to the hospital. Review of a hospital after-visit summary for Resident #1 dated 02/26/26 revealed: -The computed tomography (CT) scans of her head and cervical spine showed no evidence of intracranial bleeding or fractures. -X-rays of her pelvis and left knee showed no evidence of fracture. Review of a facility accident/incident report for Resident #1 dated 03/11/26 revealed: -The incident occurred at 3:25am in Resident #1's room. -The personal care aide (PCA) heard Resident #1 calling out. -She went to assess the situation and discovered that Resident #1 had fallen. -Resident #1 was on the floor. -She called the medication aide (MA) to the room and emergency medical services (EMS) was called. Review of a hospital after-visit summary for Resident #1 dated 03/11/26 revealed: -Resident #1 was evaluated in the hospital for a fall, facial hematoma, right hip hematoma, and laceration of the scalp. -Resident #1 had staples placed for the repair of her scalp laceration. Review of a PCP order for Resident #1 dated 03/11/26 revealed: -There was an order to place a floor mat next to the resident's bed at night. -There was an order to apply an ice pack to the right side of Resident #1's face for 15 minutes once every four hours during waking hours.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 22 Review of a facility accident/incident report for Resident #1 dated 03/16/26 revealed: -The incident occurred at 6:00pm. -Resident #1 was headed to her room and she fell by her door. -Resident #1 said her head and hip hurt. -Resident #1 was sent to the hospital. Review of a hospital after-visit summary for Resident #1 dated 03/16/26 revealed: -She was seen due to fall that occurred while at her facility. -She received a CT of her cervical spine, CT of her head, and x-ray of her chest. -Imaging completed did not show any concerning findings. -The staples that were placed on the previous visit 5 days ago were also removed due to laceration showing signs of being completely healed. Review of a facility accident/incident report for Resident #1 dated 05/31/26 revealed: -The incident took place at 8:00am. -A resident found staff and told them she heard her neighbor fall in the bathroom. -When staff arrived Resident #1 was found on the floor with her incontinence brief with urine on the floor. -There was nothing written about Resident #1's condition or injuries. -There was no indication that Resident #1's medical team had been contacted about the fall. Review of a hospital after-visit summary for Resident #1 dated 06/02/26 revealed: -Resident #1 was evaluated for a fall and chest pain. -Resident #1 had a CT of the cervical spine, CT of the head, and a chest x-ray.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 23 Telephone interview with Resident #1's power of attorney (POA) on 06/04/26 at 4:15pm revealed: -He thought the care at the facility was very good. -Resident #1 had lots of falls and had dementia but was not able to walk steadily for a distance. -When she got up in the middle of the night she fell. -The most recent fall she had was about two days ago, initially they did not send her the emergency room because they did not witness the fall. -The hospice nurse saw the bruising and recommended that she go to the hospital. -The hospital said she was fine. -She was injured but there was no damage requiring extended care at the hospital. Interview with a PCA on 06/04/26 at 10:27am revealed: -Resident #1 had a fall mat, most of the time staff would help her walk with her walker, but she could do things for herself. -She had not gotten any directions on how much assistance to provide for Resident #1. Interview with a second PCA on 06/04/26 at 10:38am revealed: -When Resident #1 laid down in the bed staff used the fall mat. -She got Resident #1 up in the mornings and got her dressed. -The hospice nurse gave Resident #1's showers. -She provided personal care and Resident #1 sat and watched TV. -When she saw Resident #1 get up she would provide assistance for the resident to get in bed. -Resident #1 got up and walked some on her own but must have a walker at all times. -She had not observed any of the falls for Resident #1.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 24 Interview with the MA on 06/04/26 at 8:58am revealed: -Resident #1 needed somebody to be with her when she moved because she had dementia. -There were only two PCAs on the hall and it took away from their jobs when Resident #1 needed to move around. -Staff were able to provide the assistance that Resident #1 needed most of the time but not fully. -When they were trying to give her showers the staff had to wait and take turns to sit with Resident #1. -Resident #1 was getting more forgetful with her dementia. -MAs completed accident reports for falls. -They send those to DSS and then they put them in an accident book. -MAs supervised the PCAs but if she told them something they would not listen. Telephone interview with Resident #1's hospice Registered Nurse on 06/04/26 at 11:03am revealed: -Resident #1's was enrolled with Hospice on 04/17/26. -She had been seeing Resident #1 now for maybe a month. -She was not notified about the most recent fall. -When she walked in on Monday (06/01/26) she saw Resident #1's face and she was shocked. -Normally they told the staff that if a patient did fall to give them a call so they could come out and assess; they would send someone out if they hit their head or anything like that. -She asked staff why she was not notified that Resident #1 fell. -The staff did not know that she had fallen and did not know how long she was on the floor. -Looking at her bruises, it looked like Resident #1	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 25	D 270		

had fallen on the floor on her face.
-When she assessed Resident #1 on that Monday (06/01/26), Resident #1 was walking to the bathroom and had urine from the top of her pants down.
-Normally, Resident #1 did not have incontinence.
-She asked staff if that was something new.
-The staff told her Resident #1 did that from time to time.
-She asked Resident #1 if she was in pain and the resident said her arms hurt so she did range of motion and Resident #1 did not report any pain.
-The only thing was Resident #1's face and she told them to put some ice on there.
-The hospice aide sent her a message at 4:00pm on Tuesday (06/02/26).
-The hospice aide said Resident #1 was more confused and unsteady.
-She spoke with her boss, then she called the facility at 5:00pm to let them know that they needed to send Resident #1 to the hosptial.
-On Monday she spoke with a POA for Resident #1 and who said nobody told him about the fall and she was the first person letting him know.
-She was visiting once or twice a week and was there 30-40 minutes.
-Normally it looked like they were taking good care of Resident #1, but this last Monday the resident had an episode of urinary incontinence and when she told the staff nobody got up to check her out or help, so she changed Resident #1 herself.
-The staff told her that in the evenings Resident #1 did want to go home and tried to leave the facility.
-Because Resident #1 was a little bit confused and her gait was not steady the resident could fall and hurt herself very badly.
-She was not sure how much attention the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 26	D 270		

paid to Resident #1 and she wondered if the resident could lay there for a long time after she fell down.
-She was not sure how long she laid in the bathroom after she fell the last time.
-She did not think the staff paid much attention.

Interview with the Administrator on 06/04/26 at 3:00pm revealed:
-Resident #1 needed limited assistance with toileting.
-They just took Resident #1 to the bathroom.
-Resident #1 would go by herself without telling staff she was going, but they were trying to catch all that.
-Staff should make rounds every two hours on each resident each night.
-She assumed Resident #1's fall on 05/31/26 was between the last round and when the staff made the next round.
-It was between the two-hour rounds, Resident #1 was in the bed and then found on the floor.
-The staff should provide limited assistance if they knew Resident #1 was going to the bathroom.
-The facility interventions for Resident #1 were physical therapy and hospice.
-Resident #1 was supervised to the best of their ability, but the resident was ambulatory.
-They were talking about discharging Resident #1 to a dementia facility at one point.
-They could not use alarms.
-Resident #1 got the halls mixed up and would go to a bathroom door.
-When the exit door alarm went off, Resident #1 made a beeline for the door at the front.
-That way she could see what happened.
-Resident #1 fell when she got up by herself at night.
-All staff were responsible for providing the level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 27 of care that was specified on the care plan. Telephone interview with Resident #1's PCP on 06/04/26 at 11:25am revealed: -They had moved Resident #1's room closer to the nurse's station to for closer monitoring. -They also rearranged her furniture in her room because she would fall out of the bed and hit her head, so they moved the furniture and she had the fall mat. -They were not allowed to set bed alarms, but staff went and checked on Resident #1. -She did not know about the fall on 05/31/26 but it got convoluted with hospice sometimes, and she was not notified of a fall on 05/31/26. -Resident #1 was at risk to wander just because of her cognition and dementia, but she thought the resident would not leave the facility and her mobility was limited. -Resident#1 would go from her room to the TV room and maybe the dining room. -Resident #1 could not walk far distances. Second interview with the Administrator on 06/04/26 at 5:02pm revealed: -The care plans should be done yearly and whenever there were significant changes. -It gave staff an idea about what level of care the residents needed, their medications and diagnoses. -It let them know how to set up the personal care logs in the computer. -She would provide oversight of the RCC by asking questions of her. -The RCC was still learning the role, and at times she did not have answers to some of their questions. -The RCC quit Monday (06/01/26), so the responsibilities of the RCC were hers now. _____	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 270	Continued From page 28 The facility failed to provide supervision according to the care plans assessed needs for a resident (#1) who fell four times between 02/26/26 and 05/31/26 resulting in injuries including bruising and a laceration which needed staples for repair. 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 in accordance with G. S. 131D-34 on 06/04/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#4) including referrals for orthopedics and neurology The findings are: Review of Resident #4's FL-2 dated 03/18/26 revealed diagnoses included essential hypertension, adult failure to thrive, abnormal weight loss, dementia, cognitive impairment.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 273	Continued From page 29	D 273		

Review of Resident #4's Resident Register revealed she was admitted to the facility on 04/28/25.

a. Review of a referral from Resident #4's primary care provider (PCP) dated 05/06/26 revealed Resident #4 was referred to Orthopedics.

Review of Resident #4's hospital after-visit summary dated 05/05/26 revealed:
-X-ray that was completed showed fracture of the humerus neck and head being present along with fractures of the 6th and 7th rib.
-Resident #4 was to follow up with the PCP for further evaluation and management.

Telephone interview with the hospice registered nurse (RN) for Resident #4 on 06/04/26 at 9:56am revealed:
-To her knowledge Resident #4 had not been seen by orthopedics.
-Hospice had not required the orthopedic visit, they were going to get a mobile x-ray in 6 weeks and talk with their doctor to see if orthopedics was needed.

Telephone interview with Resident #4's PCP on 06/04/26 at 11:25am revealed:
-She was involved in the care of Resident #4's fractured arm, she placed an orthopedic referral to a local orthopedics provider.
-She did not know if that was done.
-She did not have any notes from them.
-The previous RCC was handling all of the appointments.
-The referral was about a month ago and she would be concerned about the healing of Resident #4's shoulder.
-Orthopedics could see if the shoulder was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 273	Continued From page 30	D 273		

healing properly and if physical therapy was needed.

Refer to interview with the Administrator on 06/04/26 at 5:02pm.

b. Review of a referral from Resident #4's mental health provider (MHP) dated 10/30/25 revealed a neurology consultation for cognitive impairment was ordered.

Telephone interview with Resident #4's primary care provider (PCP) on 06/04/26 at 11:25am revealed:
-She did not know if Resident #4 was ever seen by neurology and did not have any office visit notes and had not heard of her seeing anyone.
-Neurology was for further evaluation of cognitive impairment.
-Resident #4's Mini Mental State Examination (MMSE) score was 16 so they were trying to get a consult to get a further evaluation of her cognitive status at that time (MMSE is a screening tool for cognitive impairment).

Interview with the Administrator on 06/04/26 at 5:02pm revealed:
-The facility should act on referrals immediately.
-One good thing the provider's office did for the residents was that they would call the referred provider's office and then the referred provider's office would call the facility to get an appointment.
-When she was looking at referrals before February 2026, she would make a call if she had not received one the next day.
-The Resident Care Coordinator (RCC) was responsible for referrals and follow-up and that was their job.
-The RCC quit Monday, so the responsibility was hers now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 273	Continued From page 31 Refer to interview with the Administrator on 06/04/26 at 5:02pm. Interview with the Administrator on 06/04/26 at 5:02pm revealed: -The facility should act on referrals immediately. -One good thing the provider's office did for the residents was that they would call the referred provider's office and then the referred provider's office would call the facility to get an appointment. -When she was looking at referrals before February 2026, she would make a call if she had not received one the next day. -The Resident Care Coordinator (RCC) was responsible for referrals and follow-up and that was their job. -The RCC quit Monday, so the responsibility was hers now.	D 273		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available	D 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 316	Continued From page 32 to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have a current activity calendar posted in the facility. The findings are: Observations throughout the facility during initial tour on 06/02/26 beginning at 9:14am and continuing until 10:15am revealed there was no activity calendar posted for June 2026. Observation of the posted activity calendar on 06/03/26 at 6:55am revealed: -There was a large whiteboard calendar mounted on a cork board inside a light brown wooden frame, hung on a white cinderblock wall outside the television room across the hall from the medication carts. -The calendar was formatted as a monthly calendar, though no specific month or year was written at the top.	D 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 316	Continued From page 33 -The calendar consisted of 31 days noted with the first of the month being noted as a Friday and the 31st was noted as a Sunday. -The month of June 2026 began on Monday 06/01/26 and had only 30 days. -The headers for the days of the week (Sunday through Saturday) were pre-printed in bold colors like green, red, and blue. -Hand-written notes were written in red, blue, and black dry-erase markers and filled the individual daily squares which began on Friday the 1st. -These entries included recurring events like "bingo," "movie night," "morning walks," "bible study," and various social or art hours. -The blank space at the bottom of the board were two handwritten notes in red marker that noted "activities may change!" and "feel free to give more ideas on activities." Observation of the posted activity calendar on 06/05/26 at 8:36am revealed there had been no changes made to the posted calendar. Interview with a resident on 06/02/26 at 9:10am revealed: -There were not any activities to do in the facility. -They played bingo about 3 times a week, but he did not like to play bingo. -He did not know what was planned for today because the activity calendar posted was not for this month. Telephone interview with a resident's family member on 06/03/26 at 11:18am revealed: -They had not observed any activities in the facility. -Residents playing bingo was all they had seen. -Their family came to visit several times a week and on the weekends as well. -They tried to plan things when they visited to	D 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 316	Continued From page 34 keep him engaged. Telephone interviews with the previous Resident Care Coordinator (RCC) on 06/05/26 at 9:08am and 4:22pm revealed: -She worked at the facility from January 2026 until the past Monday morning (06/01/26). -There were never any activities when she worked at the facility. -She had not seen one activity at the facility besides some pictures on the wall but that was done by the Activity Director (AD) using the computer artificial intelligence (AI). Telephone interview with the AD on 06/05/26 at 10:18am revealed: -There was usually an activity calendar posted but she had not had a chance to update it for this month since she was busy helping the Administrator with tasks since the RCC had quit. -She knew 14 hours of activities each week were required. -The residents got bored playing cards and board games. -They did enjoy bingo. Interview with the Administrator on 06/05/26 at 8:12am revealed: -The AD was responsible for developing and posting the activity calendar. -The AD was supposed to post 14 hours of activities each week as required. -The monthly activity calendar should be posted by the 1st day of the month and remain posted throughout the entire month.	D 316		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 35 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to complete a 24-hour initial allegation report and a 5-day investigation report to the Health Care Personnel Registry (HCPR) regarding allegations of physical abuse of two residents by 2 of 2 sampled staff (D and E). The findings are: 1. Review of Resident #8's current FL-2 dated 12/03/25 revealed: -Diagnoses included seizure disorder, hypertension, peripheral vascular disease, hypertension, tremors, osteoarthritis, epilepsy, chronic kidney disease, organic brain syndrome, schizophrenia, and gastroesophageal reflux disease (GERD). -The resident was documented as ambulatory. -There was no information documented regarding Resident #8's orientation. Review of Resident #8's current care plan dated 12/03/25 revealed he needed supervision for eating, transfers, and ambulation, limited assistance with toileting, extensive assistance with dressing and grooming, and was totally dependent with bathing. Interview with Resident #8 on 06/03/26 at 3:30pm	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 36	D 438		

revealed:
-Resident #8 remembered Staff E by name.
-Staff E was a "male nurse" who had assisted him with his shower.
-When asked if he was uncomfortable discussing this issue, Resident #8 said yes.
-He was more comfortable answering yes/no questions.
-When asked if he was uncomfortable having a man give him a shower, he said yes.
-When asked if he could wash his own private areas, he said no.
-When asked if it was OK for the female assistants to wash him, he said yes.
-When asked if he was uncomfortable with the females washing his private parts, he said no.
-When asked if any other male assistant or male nurse washed him or washed his private parts, he said just this one (Staff E).
-He had told the staff in the front office and when asked if it was the Resident Care Coordinator (RCC) or the Administrator, he was able to call her by name which was the former RCC.

Telephone interview with the county Adult Home Specialist (AHS) on 06/03/26 at 10:36am revealed:
-There were no incident-accident reports received by the county Department of Social Services (DSS) regarding any allegations of abuse of any residents at the facility.
-If there had been any allegation of abuse, the report would come to the AHS or Adult Protective Services (APS).
-If APS received the report, the AHS would be notified from APS.
-She was unaware of any allegations of abuse of residents from this facility.

Telephone interview with the previous RCC on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 37 06/02/26 at 4:15pm revealed: -Resident #8 was the only allegation of abuse that she was aware. -She was working at the facility when Resident #8 told her that a male employee, Staff E, fondled him while assisting him with his shower. -Staff E was as a personal care aide (PCA) on second shift. -She had Resident #8 tell the Administrator. -She did not think that it was reported to the healthcare personnel registry. -She did not think the Administrator reported anything anywhere except incident reports and falls which were reported to the county Department of Social Services (DSS). -The Administrator had told her that she (the former RCC) had to call Staff E and tell him that due to allegations against him he could not report back to work. -The Administrator never called him back to work. Interview with the Administrator on 06/04/26 at 11:03am revealed: -She had been employed at the facility for five years. -She had not reported any allegations of abuse to HCPR since her employment at the facility. -The previous Resident Care Coordinator (RCC) had told her about Resident #8 being fondled by Staff E. -She told the previous RCC to contact Staff E and tell him due to the allegations of abuse he would not be able to return to work. -He had only been employed at the facility for a short time (did not remember exact dates) before she let him go. -She defined abuse as purposely hurting someone. -If a resident alleged abuse, she was responsible for reporting the allegation to HCPR.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 38 -She had not done an internal investigation for the allegation. 2. Review of Resident #7's current FL-2 dated 10/29/25 revealed: -Diagnoses included dementia with behaviors, iron deficiency, hearing loss, hypertension, vitamin B-12 deficiency, peripheral vascular disease, schizoaffective disorder, gastroesophageal reflux disease, Alzheimer's, and psychotic disorder. -The resident was documented as semi-ambulatory. -The resident was documented as verbally abusive at times. -There was no information documented regarding Resident #7's orientation.. Review of Resident #7's current care plan dated 10/29/26 revealed: -Resident #7 was verbally abusive. -The resident was sometimes disoriented. Review of a mental health provider progress notes for Resident #7 dated 04/09/26 revealed the resident continued to exhibit tearfulness and disruptive behavior despite verbal redirection. Telephone interview with the previous Resident Care Coordinator (RCC) on 06/02/26 at 4:15pm revealed: -Resident #7 reported to her three times that a former staff had been abusive to the resident. -The first time the resident reported the abuse was about one month ago (no date provided) and the previous RCC reported it to the Administrator. -The second time the resident reported the abuse (no specific timeframe) she reported it to the Administrator on the same day, and she and the	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 39	D 438		

Administrator sat down with Resident #7, who then told the previous RCC and Administrator about the abuse.
-She had not reported the abuse to anyone else except the Administrator.
-There was no incident report written.
-The previous medication aide (Staff D) placed her hands over Resident #7's mouth and told her to "shut the [explicit] up".
-There was a written counseling statement for Staff D that was not given to Staff D, nor was it sent anywhere.
-Staff D was terminated on 05/12/2026.

Interview with Resident #7 on 06/03/26 at 2:40pm revealed:
-Resident #7 remembered Staff D by name.
-Staff D had put her hand over the residents' mouth a couple times at night when she was crying and made a scratch mark on the residents' neck.
-She could not remember specific dates when the alleged incidents occurred.
-She told a staff member in the office who told Staff D not to do it anymore.

Interview with a medication aide (MA) on 06/04/26 at 10:45am revealed:
-Resident #7 was grabbed by Staff D.
-Resident #7 told her that Staff D grabbed her again and that she (MA) reported it to the Administrator.
-She did not know what the Administrator did after she reported to her what Resident #7 told her.
-Resident #7 had a bruise on her arm but she did not know where the bruise came from.
-Resident #7 would cry a lot and had no tears, but was just making noises.

Interview with the Administrator on 06/04/26 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 40 11:03am revealed: -She had been employed at the facility for five years. -She had not reported any allegations of abuse to HCPR since her employment at the facility. -Resident #7 would scream all day. -There was one night when Resident #7 would not stop screaming no matter what was done. -Staff D reported to her that she went to Resident #7's room, put her hand over the residents' mouth and asked her to stop. -Resident #7 reported to the Administrator that Staff D put her hand over her mouth. -Resident #7 had a scratch on her neck but she was not sure where it came from. -Staff D was terminated (date not provided). -Staff D's behavior was not acceptable behavior. -There were no witnesses. -She did not have any documentation of the incident. -Staff D should have contacted her or the RCC before approaching Resident #7. She did not expect staff to discipline any residents. -She did not consider putting a hand over someone's mouth a form of hurting someone. -She defined abuse as purposely hurting someone. -Resident #7 told her that Staff D touched her mouth twice, but Staff D reported doing it once. -If a resident alleged abuse, she was responsible for reporting the allegation to HCPR. -She had not done an internal investigation for the allegation. _____ The facility failed to complete an initial report within 24 hours, investigate and complete an investigation report with 5 days for 2 of 2 sampled resident (#7) who had a previous staff put her hand over the residents' mouth, and a resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 438	Continued From page 41 (#8) who was allegedly fondled by a previous male staff during bathing. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/26 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2026.	D 438		