

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0000	INITIAL COMMENTS  An unannounced complaint investigation was conducted from 04/21/26 through 04/22/26. Additional information was gathered offsite on 04/23/26, therefore, the exit date was changed to 04/23/26. Event ID #1DD8D7-H1. The following intakes were investigated #2624641, #2667103, #2793025, #2975856 and #2983576.  One (1) of the ten (10) allegations resulted in deficiency.	F0000		05/08/2026
F0600 SS = G	Free from Abuse and Neglect  CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation  The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and interviews with staff, the facility failed to protect a resident's right to be free from staff to resident physical abuse when Nurse Aide #2 hit a severely cognitive impaired resident with an open hand three times during care. Resident #1 did not have the cognitive capacity to express an adverse psychosocial outcome. A reasonable person would have experienced feelings such as fear, anxiety, helplessness, and dehumanization from being abused by their	F0600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.  F600  Resident #1 was immediately removed from the situation and placed in a supervised setting following the incident. A full nursing assessment and body audit were completed with no injury identified. · The physician, responsible party, Adult Protective Services, and law enforcement were notified per policy. The alleged perpetrator (NA #2) was immediately removed from resident care, suspended, and subsequently no longer employed at the facility.  The 200 Hall Unit Manager and 300 Hall Unit Manager completed skin assessments for residents unable to be reliably interviewed (BIMS ≤12) on the 200 and 300 Halls, with no concerns identified. This was completed on 4/20/26.  The Administrator and Social Work team members-initiated interviews with alert and oriented residents (BIMS ≥13) on the 200 and 300 Halls where CNA #1 had previously worked. No concerns related	05/21/2026

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

<p><b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b></p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b></p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING</p>	<p>(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b></p>	
<p>NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b></p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b></p>		
(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) COMPLETION DATE
<p>F0600 SS = G</p>	<p>Continued from page 1 caregiver. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 2/2/26 with diagnoses that included Alzheimer's disease.</p> <p>Resident #1's admission Minimum Data Set (MDS) dated 2/11/26 revealed she was coded with severe cognitive impairment and needed moderate assistance with personal hygiene, toileting hygiene, dressing and transfers. She was always incontinent of bowel and bladder and did not have any behaviors during the 7-day look back.</p> <p>Resident #1 was care planned on 3/2/26 for combative behaviors with care. The interventions included to assure the resident she is safe, listen to the resident, and try to calm the resident.</p> <p>The initial allegation report completed by the Administrator on 4/14/26 and submitted at 2:42 PM for an allegation of resident abuse for Resident #1 that the facility was made aware of at 1:45 PM. The summary of the incident indicated during a two-person care interaction, Nurse Aide (NA) #1 alleged NA #2 slapped Resident #1 three times while the resident was combative, trying to punch and bite staff. NA #1 immediately notified the Unit Manager and NA #2 was promptly suspended pending investigation. Skin assessment of the resident revealed no concerns.</p> <p>A review of Resident #1's body audit completed on 4/14/26 by the Wound Nurse found no new marks, redness or wounds.</p> <p>NA #2's written statement on 4/14/26 revealed: "A NA said that I hit a resident today and I did not do so."</p> <p>NA #2 was unavailable for interview.</p> <p>NA #1 stated during an interview on 4/21/26 at 12:10 PM that on 4/14/26 around 1:30 PM, NA #2 asked her for assistance with providing care to</p>	<p>F0600</p>	<p>Continued from page 1 to abuse or feelings of being unsafe were identified. This was completed on 4/20/26.</p> <p>Current staff were re-educated by the Staff Development Coordinator (SDC) or designee regarding abuse prohibition, mandatory reporting expectations, dementia care approaches, and appropriate de-escalation techniques when residents display agitation or combative behaviors. Staff were instructed to pause care when safety concerns arise, seek assistance, and report concerns immediately. Staff were also educated on stopping care and removing the resident at the time the abuse occurs the first time. This was completed on 05/21/2026.</p> <p>Any staff member who has not received this education will receive this education prior to the start of their shift by the Director of Nursing or Designee.</p> <p>New staff will receive education during the orientation process provided by the Director of Nursing or Designee.</p> <p>The Administrator or designee will administer abuse prevention of knowledge quiz audits to all staff throughout the facility. This will be completed by 10 employees weekly for 4 weeks and 5 employees weekly for 8 weeks.</p> <p>The Director of Nursing or Designee will perform random audits of resident care interaction to ensure no evidence of physical or mental abuse was observed 10x weekly x 12 weeks.</p> <p>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.</p> <p>Date of compliance: 5/21/2026</p>	<p>05/21/2026</p>

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0600 SS = G	Continued from page 2 Resident #1. Resident #1 had a history of being resistive to care, and NA #1 assumed NA #2 had attempted to provide care to the resident and needed more help. When NA #1 walked into Resident #1's room, she noticed the resident was agitated. She explained the resident was swinging her arms and had a frown on her face, which was the resident's typical behavior when agitated. Resident #1 was leaning up from her bed with one leg hanging off her bed, and NA #1 then informed the resident they were going to change, dress and get her out of bed. NA #1 said she was going to provide incontinence care and dress the resident's lower half and NA #2 was going to dress the resident's top half of her body. Resident #1 was laid down on her bed and rolled over on her side. The resident grabbed and held on the bed rail making it difficult to move the resident. NA #2 removed the resident's hands from the bed rail. NA #1 stated Resident #1 then tried to bite NA #2. NA #2 then "popped the resident on the lips, like someone would discipline a child" with an open hand and said, "you're not going to fight us or bite us". The strike to the resident's mouth made an audible "pop" sound. NA #1 said she was in the middle of providing incontinence care to the resident and was shocked by what NA #2 had done. After NA #2 had "popped" the resident, she continued to provide care to the resident's upper body. The resident became more agitated right after the "pop" and started kicking her legs, making it difficult to finish care. NA #1 stated her thought was she needed to quickly finish providing care to Resident #1, get her dressed and remove her from NA #2. After she completed incontinence care, NA #1 told NA #2 she (NA #1) would finish getting Resident #1 dressed, and NA #2 did not need to help with care anymore. NA #1 indicated she then took charge of providing care. NA #1 said NA #2 remained in the room and was standing back away from the resident. She stated that she did not know why NA #2 stayed in the room. NA #1 reported she positioned Resident #1 sitting upright on the edge of the bed to change the resident's shirt. NA #2 was standing near the end of the bed facing NA #1 and behind the resident. While putting on a new shirt, the resident's arm was stuck in the shirt, and NA #1 told Resident #1 she needed to put her arm through the shirt. NA #1 said while helping the resident with her arm, Resident #1 swung at her. NA #2 then struck Resident #1 on the left side of her face/cheek area with an open hand with the same level of force as the first strike (strong enough to be felt, but not hard) and heard an audible "pop" sound from the strike. NA #2 repeated to the resident "you're not going to fight us or bite us". After the strike, Resident #1's facial expressions appeared more agitated and intense, and she did not	F0600		05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0600 SS = G	<p>Continued from page 3 make any noise. NA #1 then told NA #2 to "please stop, I have this, I just need to transfer her to her chair". NA #1 reiterated that she did not know why NA #2 remained in the room because NA #2 was not helping provide care at that time. NA #1 then began to transfer the resident to her wheelchair and Resident #1 began to swing her arms at NA #1. Resident #1 was mid-transfer when NA #2 "popped" the resident on the back of her head with an open hand and repeated, "you're not going to hit us". NA #1 did not hear an audible sound from the strike to the head. NA #1 stated she told NA #2 to "stop, I've got this" and quickly transferred the resident to her wheelchair and removed the resident from the room so she was away from NA #2. NA #1 said she wheeled the resident to the dining area on the hall and immediately went to the Unit Manager to report the incident.</p> <p>NA #1 stated in a follow-up interview on 4/21/26 at 2:30 PM that Resident #1 did not make any noise after each strike from NA #2. The resident appeared to look more agitated with her facial expressions. NA #1 explained that she was in shock and in process of changing the resident after the first strike, and did not want to leave the resident naked. NA #1 said the second and third strike on Resident #1 happened within 45 seconds and her thought was to get the resident away from NA #2 as quickly as possible. NA #1 stated in retrospect, she should have stopped care with the resident after the first strike on Resident #1, removed NA #2 from the room, and reported the incident to the Unit Manager.</p> <p>The DON stated during interview on 4/22/26 at 2:00 PM that NA #1 and NA #2 should have stopped providing care to the resident when she became agitated. She added that NA #1 should have asked NA #2 to leave the resident's room after the first strike on the resident and reported the incident to a nurse.</p> <p>On 4/22/26 at 2:00 PM the Administrator was interviewed. The Administrator stated on 4/14/26 the Unit Manager and NA #1 reported to him and the Director of Nursing (DON) that NA #2 had struck Resident #1 three times during the provision of care. The DON told the Unit Manager to remove NA #2 from the hall and bring her to their office. The Unit Manager then immediately completed a skin assessment on Resident #1. The Administrator stated the skin assessment of Resident #1 found no new signs of bruising or redness on the resident. When</p>	F0600		05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345570	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  04/23/2026	
NAME OF PROVIDER OR SUPPLIER  Huntersville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  13835 Boren Street , Huntersville, North Carolina, 28078		
(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) COMPLETION DATE
F0600 SS = G	Continued from page 4 NA #2 arrived in their office, the DON asked NA #2 to write a statement about the incident. NA #2 said that nothing had happened. At that time, the DON told NA #2 that an allegation of abuse had been made and NA #2 was not able to work until the investigation was completed. The DON then escorted NA #2 out of the building. The Administrator stated NA #1 told him and the DON that NA #1 and NA #2 were performing care to Resident #1. NA #1 said Resident #1 tried to bite NA #2 and she (NA #2) told the resident, "You're not going to hit or bite us", and then NA #2 placed her hand over the mouth of Resident #1. The Administrator indicated that NA #1 said she was in shock but did not stop providing incontinence care. NA #1 then reported she sat the resident up at the edge of the bed to put her shirt on and Resident #1 swung her arms at NA #1. The Administrator stated NA #2 then made contact with her open hand on the left side of the resident's face. Care continued and Resident #1 continued to have behaviors when NA #1 was transferring the resident from bed to chair. That was when NA #2 made contact with her open hand on the back of the resident's head. NA #1 then removed Resident #1 from the room away from NA #2 and reported it to the Unit Manager. The Administrator reported that after the incident, the resident was placed at nursing station to be visible, and the resident was in a good mood and no signs of distress. The Resident's family, physician, police, and Adult Protective Services (APS) were all notified and the state initial report was submitted. The Administrator added the abuse allegation was unsubstantiated because the resident did not remember what happened, there were no visible marks or bruises on the resident, and NA #1 was the only witness to say the resident was hit by NA #2. He added that he was unaware of any prior disagreements between the two NAs. The Administrator stated NA #2 was terminated from the facility on 4/20/26 because of other work-related issues not related to the abuse allegation.	F0600		05/21/2026
F0604 SS = G	Right to be Free from Physical Restraints  CFR(s): 483.10(e)(1),483.12(a)(2)  §483.10(e) Respect and Dignity.  The resident has a right to be treated with respect and dignity, including:  §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0604	F604  A full nursing assessment and skin audit were completed by the 300 Hall Unit Manager and Wound Nurse with no injury identified. Staff instructed to discontinue unsafe care attempts during combative episodes by the SDC on 05/15/26.  An audit of current residents identified with behaviors/care resistance to ensure: No unintended restraints are in use; Care plans include appropriate behavioral interventions; Direct observation audits	05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0604 SS = G	Continued from page 5  §483.12  The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and interviews with staff, the facility failed to protect the resident's right to be free from physical restraints when Nurse Aide #2 was witnessed by another staff member (Nurse Aide #1) to hold Resident #1's hands down against her chest to restrict her arm movements during care when the resident became combative. Resident #1 did not have the cognitive capacity to express an adverse psychosocial outcome. A reasonable person would have experienced feelings such as panic, distress, anger, and fear from being physically restrained by their caregiver. This deficient practice affected 1 of 1 resident reviewed for physical restraints (Resident #1).  Findings included:  Resident #1 was admitted to the facility on 2/2/26 with diagnoses that included Alzheimer's disease.  Resident #1's Admission Minimum Data Set (MDS) dated 2/11/26 revealed she was coded with severe cognitive impairment and did not have any behaviors during the 7-day look back period.  Resident #1 was care planned on 3/2/26 for combative behaviors with care. The interventions included to assure the resident she is safe, listen to the resident, and try to calm the resident.	F0604	Continued from page 5 conducted of ADL care delivery by DON.  Current staff are educated by the Staff Development Coordinator ( SDC) regarding the definition of restraint including manual holds by 05/21/2026.  Any staff member not receiving education will receive education prior to the start of their shift from the SDC or designee.  Any new staff member will receive education during the orientation process by the SDC or designee.  The Director of Nursing or Designee will perform random audits of resident care interaction to ensure no evidence of physical or mental abuse including manual restraints was observed 10x weekly x 12 weeks.  Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.  Date of compliance: 5/21/2026	05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0604 SS = G	<p>Continued from page 6</p> <p>The investigation report completed by the Administrator on 4/20/26 related to an allegation of staff to resident abuse for Resident #1 indicated Nurse Aide (NA) #1 reported while she was attempting to remove the resident's brief on 4/14/26 NA #2 was holding Resident #1's hands to prevent injury.</p> <p>NA #1 stated during an interview on 4/21/26 at 12:10 PM that on 4/14/26 around 1:30 PM, NA #2 asked her for assistance with providing care to Resident #1. Resident #1 had a history of being resistive to care, and NA #1 assumed NA #2 had attempted to provide care to the resident and needed more help. When NA #1 walked into Resident #1's room, she noticed the resident was agitated. She explained the resident was swinging her arms and had a frown on her face, which was the resident's typical behavior when agitated. Resident #1 was leaning up from her bed with one leg hanging off her bed, and NA #1 informed the resident they were going to change, dress and get her out of bed. NA #1 said she was going to provide incontinence care and dress the resident's lower half and NA #2 was going to dress the resident's top half of her body. Resident #1 was laid down on her bed and rolled over on her side. The resident grabbed and held on the bed rail making it difficult to move the resident. NA #2 removed the resident's hands from the bed rail, placed them on the resident's upper chest and held her hands there to prevent the resident from swinging her arms. NA #2 held Resident #1's hands until NA #1 completed incontinence care for the resident. NA #1 stated Resident #1 then tried to bite NA #2 while she was holding the resident's hands down. NA #2 then "popped the resident on the lips, like someone would discipline a child" with an open hand and said, "you're not going to fight us or bite us", as she continued to restrain the resident's hands. The resident became more agitated after being "popped "on the lips while her hands were held down and started kicking her legs, making it difficult to finish care.</p> <p>NA #1 stated in a follow-up interview on 4/21/26 at 2:30 PM that she had received training on how to deal with residents who have behaviors, and on abuse. NA #1 did not realize at the time of the incident that NA #2 holding the resident's hands down on her chest was a restraint. NA #1 added, she and NA #2 should have stopped care when Resident #1 was being combative and tried again later.</p> <p>NA #2 was unavailable for interview.</p>	F0604		05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0604 SS = G	Continued from page 7 The Director of Nursing (DON) stated during interview on 4/22/26 at 2:00 PM, NA #1 had reported to her and the Administrator that NA #2 was holding Resident #1's hands against the resident's chest to prevent the resident from getting injured while care was being provided. She added that holding Resident #1's hands prevented the resident from injuring herself if she swung her arms and hit the bed rail. The DON indicated that NA #1 reported that Resident #1's hands were restrained when NA #2 struck the resident. She reported that she and the Administrator had not considered holding the resident hands as a restraint since it was to prevent the resident from injuring herself. She indicated that NA #1 and NA #2 should have stopped providing care when the resident became combative, told a nurse and attempted care later. The DON stated that staff had received previous training on all types of abuse that included physical restraints.  During an interview on 4/22/26 at 2:00 PM the Administrator voiced her agreement with the DON that the NAs should have stopped providing care to Resident #1 when she became combative, reported to a nurse and attempted care later.	F0604		05/21/2026
F0607 SS = G	Develop/Implement Abuse/Neglect Policies  CFR(s): 483.12(b)(1)-(5)(ii)(iii)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95,  §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.  §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not	F0607	F607  Resident #1 was immediately removed from the situation and placed in a supervised setting following the incident. A full nursing assessment and body audit were completed with no injury identified. · The physician, responsible party, Adult Protective Services, and law enforcement were notified per policy. The alleged perpetrator (CNA #2) was immediately removed from resident care, suspended, and subsequently no longer employed at the facility. CNA #1 was provided immediate education on how to properly intervene when abuse is witnessed and to not allow care to continue or continued abuse by the Administrator and DON. This was completed at the time of the occurrence.  The 200 Hall Unit Manager and 300 Hall Unit Manager completed skin assessments for residents unable to be reliably interviewed (BIMS ≤12) on the 200 and 300 Halls, with no concerns identified. This was completed 4/20/26  The Administrator and Social Work team members-initiated interviews with alert and oriented residents (BIMS ≥13) on the 200 and 300 Halls where	05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0607 SS = G	<p>Continued from page 8 limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interviews with staff, the facility failed to implement their policy and procedure in the areas of protection, prevention and reporting abuse for 1 of 3 residents reviewed for abuse (Resident #1). NA # 2 witnessed NA # 1 strike a cognitively impaired resident (Resident #1) and did not effectively intervene or immediately report to nursing or administration; this resulted in NA # 2 striking the resident two more times. A reasonable person would expect a witness to remove a cognitively impaired, vulnerable resident from an abusive situation and protect them from further abuse. A reasonable person would feel very dehumanized and helpless from repeated physical abuse.</p> <p>Findings included:</p> <p>The facility's abuse policy dated 10/17/23 was reviewed. The policy read "all employees are responsible for immediately reporting to the Administrator, or in their absence the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incident of patient abuse". The policy included "the prevention of abuse and neglect...by advocating and enforcing resident patient rights and reporting incidents".</p> <p>Resident #1 was admitted on 2/2/26 with diagnoses that included Alzheimer's disease.</p> <p>Nursing Assistant (NA) #1 was interviewed on 4/21/26 at 12:10 PM and stated that on 4/14/26 around 10:30 AM, NA #2 asked her for assistance providing care to Resident #1. Resident #1 had a history of being resistive to care, and NA #1 assumed NA #2 had attempted to provide care to the resident and needed more help. When NA #1 walked into Resident #1's room, she noticed the resident was agitated. Resident #1 was leaning up from her bed with one leg hanging off her bed, and NA #1 then informed the resident they were going to change, dress and get her out of bed. NA #1 said</p>	F0607	<p>Continued from page 8 CNA #1 had previously worked. No concerns related to abuse or feelings of being unsafe were identified. This was completed on 4/20/26.</p> <p>Current staff were re-educated by the Staff Development Coordinator (SDC) or designee regarding abuse prohibition, mandatory reporting expectations, dementia care approaches, and appropriate de-escalation techniques when residents display agitation or combative behaviors. Staff were instructed to pause care when safety concerns arise, seek assistance, and report concerns immediately. Staff were also educated on stopping care and removing the resident at the time the abuse occurs the first time. This was completed on 05/21/2026</p> <p>Any staff member who has not received this education will receive this education prior to the start of their shift by the Director of Nursing or Designee.</p> <p>New staff will receive education during the orientation process provided by the Director of Nursing or Designee.</p> <p>The Administrator or designee will administer abuse prevention of knowledge quiz audits to all staff throughout the facility. This will be completed by 10 employees weekly for 4 weeks and 5 employees weekly for 8 weeks.</p> <p>The Director of Nursing or Designee will perform random audits of resident care interaction to ensure no evidence of physical or mental abuse was observed 10x weekly x 12 weeks</p> <p>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.</p> <p>Date of compliance: 5/21/2026</p>	05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0607 SS = G	<p>Continued from page 9 she was going to provide incontinence care and dress the resident's lower half and NA #2 was going to dress the resident's top half of her body. Resident #1 was laid down on her bed and rolled over on her side. The resident grabbed and held on to the bed rail making it difficult to move the resident. NA #2 removed the resident's hands from the bed rail, placed them on the resident's upper chest and held them to prevent swinging from the resident. NA #1 stated Resident #1 then tried to bite NA #2 while she was holding the resident's hands. NA #2 then "popped the resident on the lips, like someone would discipline a child" with an open hand and said "you're not going to fight up or bite us". NA #1 said she was in the middle of providing incontinence care to the resident and was shocked by what NA #2 had done. The resident became more agitated and started kicking her legs, making it difficult to finish care. NA #1 stated her thought was she needed to quickly finish providing care to Resident #1, get her dressed and remove her from NA #2. After she completed incontinence care, NA #1 told NA #2 she would finish getting Resident #1 dressed, and NA #2 did not need to help with care anymore and NA #1 took charge of providing care. NA #1 positioned Resident #1 sitting upright on the edge of the bed to change the resident's shirt. NA #2 was standing near the end of the bed facing NA #1 and behind the resident. While putting on a new shirt, the resident's arm was stuck in the shirt, NA #1 told Resident #1 she needed to put her arm through the shirt. NA #1 said while helping the resident with her arm, Resident #1 swung at her. NA #2 then struck Resident #1 on the left side of her face/cheek area with an open hand with the same level of force as the first strike. NA #2 repeated to the resident "you're not going to fight us or bite us". NA #1 then told NA #2 to "please stop, I have this, I just need to transfer her to her chair". NA #1 then began to transfer the resident to her wheelchair and Resident #1 began to swing her arms at NA #1. Resident #1 was mid-transfer when NA #2 "popped" the resident on the back of her head with an open hand and repeated, "you're not going to hit us". NA #1 stated she told NA #2 to "stop, I've got this" and quickly transferred the resident to her wheelchair and removed the resident from the room away from NA #2. NA #1 said she wheeled the resident to the dining area on the hall and immediately went to the Unit Manager to report the incident.</p> <p>NA #1 stated in a follow-up interview on 4/21/26 at 2:30 PM that Resident #1 did not make any noise after each strike from NA #2. The resident appeared to look more agitated with her facial expressions. NA #1 said she was in shock and in process of</p>	F0607		05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0607 SS = G	<p>Continued from page 10</p> <p>changing her, did not want to leave the resident naked after the first strike. NA #1 said the second and third strike on Resident #1 happened within 45 seconds of each and her thought was to get the resident away from NA #1 as quickly as possible. NA #1 stated in retrospect, she should have stopped care with the resident after the first strike on Resident #1, removed NA #2 from the room, and reported the incident to the Unit Manager.</p> <p>NA #2 was unavailable for interview.</p> <p>The Director of Nursing (DON) stated on 4/22/26 at 2:00 PM NA #1 and NA #2 should have stopped providing care to the resident when she became agitated. She added NA #1 should have asked NA #2 to leave the residents room after the first strike on the resident and reported the incident to her nurse.</p> <p>On 4/22/26 at 2:00 PM the Administrator was interviewed. The Administrator stated on 4/14/26 the Unit Manager and NA #1 reported to him that NA #2 had struck Resident #1 three times during the provision of care. The DON told the Unit Manager to remove NA #2 from the hall and bring her to their office. The Unit Manager then immediately completed a skin assessment on Resident #1. The Administrator stated the skin assessment of Resident #1 found no new signs of bruising or redness on the resident. When NA #2 arrived in their office, the DON asked NA #2 to write a statement about the incident. NA #2 said that nothing had happened then the DON told NA #2 that an allegation of abuse had been made and NA #2 was not able to work until the investigation was completed. The DON then escorted NA #2 out of the building. The Administrator then stated NA #1 told him and the DON, that NA #1 And NA #2 were performing care to Resident #1. NA #1 said Resident #1 tried to bite NA #2 and she told the resident, "You're not going to hit or bite us", and then NA #2 placed her hand over the mouth of Resident #1. The Administrator said NA #1 said she was in shock but did not stop providing incontinence care. NA #1 then reported she sat the resident up at the edge of the bed, to put her shirt on and Resident #1 swung her arms at NA #1. The Administrator stated NA #2 then made contact with her open hand on the left side of the resident's face. Care continued, and Resident #1 continued to have behaviors when NA #1 was transferring the resident from bed to chair, and NA #2 made contact with her open hand on the back of the resident's head. NA #1 then removed Resident #1 from the room away from NA #2 and reported it to the Unit Manager. The Administrator said once the skin</p>	F0607		05/21/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Huntersville Health &amp; Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>13835 Boren Street , Huntersville, North Carolina, 28078</b>	
(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) COMPLETION DATE
F0607 SS = G	Continued from page 11 assessment was completed, the resident was placed at nursing station to be visible, and the resident was in a good mood and no signs of distress. The Residents family, physician, police, and Adult Protective Services (APS) were all notified and the state initial report was sent to the state. The Administrator added the abuse allegation was unsubstantiated because the resident did not remember what happened, there were no visible marks or bruises on the resident, and NA #1 was the only witness to say the resident was hit by NA #2, and he was unaware if there had been any prior disagreement between the two NA's . Furthermore, NA #1 and NA #2 should have stopped providing care when the resident became combative, told a nurse and attempted to provide care later. NA #1 should have removed NA #2 from the resident's room after the first strike to protect the resident and reported it to the Unit Manager. The Administrator said NA #2 was terminated from the facility on 4/20/26 because of other work-related issues not related to the abuse allegation.	F0607		05/21/2026