STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntersville Health & Rehabilitation Center	13835 Boren Street Huntersville, NC 28078

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 caregiver. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #1).Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease. Resident #1's admission Minimum Data Set (MDS) dated [DATE] 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. 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. 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. A review of Resident #1's body audit completed on 4/14/26 by the Wound Nurse found no new marks, redness or wounds. 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.NA #2 was unavailable for interview. 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 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 (continued on next page)

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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. 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. 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. 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 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 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included Alzheimer's disease.Resident #1's admission Minimum Data Set (MDS) dated [DATE] 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.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. 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. 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. NA #2 was unavailable for interview.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 (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings included: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. Resident #1 was admitted on [DATE] with diagnoses that included Alzheimer's disease.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 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. 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 changing her, did not want to leave the (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	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. NA #2 was unavailable for interview.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. 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 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.