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	06/12/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications kept at bedside for 1 of 3 resident reviewed for self-administration (Resident #46). The findings included: Resident #46 was admitted to the facility on [DATE] with diagnosis of arthritis. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #46 cognitively intact. Review of Resident #46's medical records revealed no documentation Resident #46 was assessed to safely self-administer medications. A physician order dated 03/17/26 revealed an order for Tylenol 325 milligram (mg) give 2 tablets by mouth every 6 hours as needed for pain. Resident #46 did not have a physician's order for decongestant nasal spray. On 06/08/26 at 2:25 PM Resident #46 was observed to have a bottle of over the counter (OTC) Tylenol 325 milligrams (mg) and a bottle of decongestant nasal spray sitting on her bedside table. Resident #46 stated she had the Tylenol medication for when she worked with therapy services, she would take one prior to receiving therapy to alleviate pain and one tablet would help her pain level for a duration of 3 days. Resident #46 stated she would use the decongestant nasal spray one spray to each nostril daily for congestion. She explained she had received the medication from a family member who brought it into the facility for her. Resident #46 stated the medication had been sitting on her bedside table for a couple of weeks and no staff member had mentioned anything to her about it. An observation of Resident #46's room conducted on 06/09/26 at 12:15 PM revealed a bottle of over the counter (OTC) Tylenol 325 milligrams (mg) and a bottle of decongestant nasal spray sitting on her bedside table. An observation of Resident #46's room conducted on 06/10/26 at 9:00 AM revealed a bottle of over the counter (OTC) Tylenol 325 milligrams (mg) and a bottle of decongestant nasal spray sitting on her bedside table. An interview and observation were conducted on 06/10/26 at 9:10 AM with Nurse #1. The interview revealed she was not aware of any medication on Resident #46's bedside table. She explained that there were no residents in the facility allowed to keep medications at the bedside nor were there any residents on the unit assessed to self-administer medications. She stated she was unaware Resident #46 was taking Tylenol 325 mg or using the decongestant nasal spray. Nurse #1 was observed to go into Resident #46's room and pick up the bottle of Tylenol along with the bottle of nasal spray and place it at the nurses' station. She explained she would contact Resident #46's family member and let them know to pick up the medication. On 06/11/26 at 11:38 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated no resident in the facility was allowed to keep medication from home in their room. She explained Family Members were notified of the facility policy regarding medication storage upon admission but would often bring in item's to residents without staff knowledge. The DON stated Resident #46 should have been assessed to self-administer medication if she wanted to keep and administer the medications in her room. On 06/11/26 at 11:41 AM an interview was conducted with the Administrator. He stated he expected the nurses to be observant of medication at bedside and if they saw any medication at the bedside to immediately remove it.

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a Level II Preadmission Screening and Resident Review (PASRR) evaluation request to North Carolina Medicaid Uniform Screening Tool (NC MUST-an internet-based application utilized to communicate and manage PASRR requests) for a resident diagnosed with a serious mental illness. This deficient practice affected 1 of 3 residents reviewed for coordination of PASRR assessments (Resident #10).The findings included:A review of Resident #10's medical record revealed that Resident #10 was deemed by the State to be Level I PASSR. The Level I PASSR was dated 8/21/2009 with no expiration date. Resident #10 was admitted to the facility on [DATE] with diagnoses which included dementia, depression and anxiety.A review of Resident #10's medical record revealed a hospital stay from 10/18/2025 to 10/22/2025. A review of an updated North Carolina Medicaid Long Term Care FL-2 form (FL-2) dated 10/22/2025 and completed by the hospital physician indicated Resident #10 had a diagnosis of bipolar disorder.Resident #10 had a physician order dated 10/22/2025 for venlafaxine hydrochloride (an antidepressant) 75 milligrams (mg) taken orally every morning for depression; venlafaxine hydrochloride 150 mg taken orally once daily for depression; and buspirone hydrochloride (an antianxiety medication) 10 mg, taken orally, three times a day for anxiety.Bipolar disorder was added to Resident #10's facility diagnoses list on 10/22/2025.There was no documentation that a Level II PSARR evaluation was completed when Resident #10 had the addition of a new serious mental illness.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively intact. The MDS coded Resident #10 with bipolar disorder and use of antidepressant medication. The MDS indicated Resident #10 had not been evaluated by Level II PASRR and determined to have a serious mental illness.Further review of Resident #10's medical record indicated a physician's order dated 5/19/2026 for lorazepam (used to treat anxiety) one (1) mg, taken orally 3 times a day for anxiety; and mirtazapine (an antidepressant) 15 mg taken orally at bedtime for depression. An interview with the Discharge Planning Director was conducted on 6/10/2026 at 10:25 AM. The Discharge Planning Director indicated that assuring the Level II PASSR evaluations were current and accurate was her responsibility. The Discharge Planning Director reported that she became aware that Resident #10 required a Level II PASRR evaluation when Resident #10 returned to the facility after a hospital stay from 4/26/2026 to 5/8/2026. While the hospitalization was not related to psychiatric issues, the Discharge Planning Director stated the hospital discharge summary noted the bipolar disorder diagnosis. The Discharge Planning Director indicated she had missed the addition of the bipolar disorder diagnosis for Resident #10 in 10/2025 by mistake. The Discharge Planning Director indicated that she had started to work on the Level II PASRR evaluation request by obtaining an updated FL-2 form from the Medical Director which was completed and signed on 5/19/2026. The Discharge Planning Director reported she had not requested the Level II PSARR evaluation or submitted the FL-2 form to NC MUST until 6/9/2026 (yesterday). The Discharge Planning Director stated she uploaded the clinical documents for the Level II PSARR evaluation review to NC MUST on 6/10/2026 which would trigger an onsite Level II evaluation with Resident #10. An interview with the Administrator was conducted 6/11/2026 at 8:15 AM. The Administrator indicated the Discharge Planning Director was responsible for submitting requests for the Level II PASSR evaluations. The Administrator explained the Discharge Planning Director missed Resident #10's Level II PSARR evaluation by mistake and the evaluation should have been done immediately when the Discharge Planning Director realized the diagnosis warranted a screening. The Administrator stated his expectation was that the Level II PASRR evaluations would be accurate and up to date.