STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/16/2024 through 12/19/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8K3O11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/2024 through 12/19/2024. Event ID# 8K3O11. The following intakes were investigated NC00224222, NC00225186, NC00224438, NC00222140, NC00222193 and NC00222144. 8 of the 26 allegations resulted in deficiency. The 2567 was amended on 1/17/25 to reflect changes as result of IDR.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		1/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/20/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 561	Continued From page 1 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews of the staff, a family member, and the resident, the facility failed to honor a dependent resident's preference for a shower and provided a bed bath instead (Resident #62). This deficient practice affected 1 of 3 sampled residents. Findings included: Resident #62 was admitted to the facility on 6/26/24 with the diagnosis of stroke. The quarterly Minimum Data Set dated 11/14/24 for Resident #23 documented her cognition was moderately impaired. She was able to make herself understood and understands and had not refused care. The resident required substantial assistance for bathing, dressing, and personal care. There was a care plan dated 12/5/24 for Resident #62 that included an activities of daily living (ADL) deficit which required assistance with bathing.	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 F561 The facility failed to honor a dependent resident request for staff assistance to honor her preference for a shower. (Resident #24) 1. Corrective action for resident(s) affected by the alleged deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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

F 561

Continued From page 2

Resident #62's Nursing Assistant (NA) Kardex documented she was to receive showers on Wednesday and Saturday on evening shift.

A review of Resident 62's ADL sheets for 11/23/24 through 12/20/24 documented the resident had a bed bath every day and had refused 2 showers.

The Administrator provided the 11/23/24 through 12/20/24 activities of daily living for showers documented the list of NA signatures for Resident #62's scheduled shower dates which revealed "NO, N/A (not applicable) and REFUSED" on the Kardex.

NA Kardex shower documentation for Resident #62 was as follows:
o 11/23/24 NA #3 NO
o 11/27/24 NA #6 REFUSED
o 11/30/24 NA #2 NO
o 12/4/24 NA #2 N/A
o 12/7/24 NA #1 NO
o 12/11/24 NA #8 REFUSED
o 12/14 NA #2 N/A
o 12/18/24 NA #2 N/A
o 12/20/24 NA #2 N/A

On 12/19/24 at 10:53 am Resident #62's bathing and shower record for 11/23/24 through 12/20/24 was reviewed with the Administrator. The NAs documented the showers were not done by response of NO, N/A and two refusals.

On 12/16/24 at 3:01 pm an interview was conducted with Resident #62's family member. He stated the resident was mostly non-verbal but could nod her head for yes and no. He stated the resident was not getting showers 2 times a week and she wanted her showers.

F 561

Resident #24 was showered on 12/16/2024 by the assigned certified nursing assistant and the task was documented as completed on the resident shower sheet.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice. On 1/10/2025 the Director of Nurses/ Staff Development Coordinator and Unit Manager audited all residents care plans for an identified bathing preference. The results included: All residents had an identified preference for a shower.
On 01/10/2025 the Director of Nurses/Staff Development Coordinator/Unit Manger audited the residents provided bathing method for the last 7 days to assure their bathing preference was being followed. The results included: All received showers on 01/03/2025 -1/09/2025 by the assigned certified nursing assistant.
As of 01/17/2025 all residents bathing preferences were being honored and residents are receiving showers.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 01/14/2025 the Staff Development Coordinator began education to all full time, part time, PRN and agency Nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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

F 561

Continued From page 3

On 12/16/24 at 2:40 pm Resident #62 was interviewed using yes and no questions. The resident had responded with a head nod of "no" when asked if she had received her shower.

On 12/19/24 at 9:00 am an interview was conducted with Resident #62. She answered yes/no head nod. The resident nodded that she had not received her showers.

On 12/19/24 at 9:18 am Nurse #4 was interviewed. Nurse #4 stated she was not aware Resident #62 had not received her showers and she was not informed the resident had refused care.

On 12/19/24 at 9:32 an interview was conducted with NA #7. NA #7 stated she was very familiar with Resident #62. The resident was scheduled twice a week Wednesday and Saturday on evening shift for her showers. The NA stated evening shift does not always provide the shower and the NA tried to fit in showers on day shift that were not completed on evening shift. The NA stated there were a couple of residents that had reported to the NA they had not received their showers on evening shift as scheduled.

On 12/19/24 at 12:24 PM an interview was unsuccessful with NA #3.

On 12/19/24 at 11:58 am NA #1 was interviewed. NA #1 stated she knew the resident well. The resident had already gotten a bed bath on day shift which was received in report and documented NO in the Kardex the shower was not given on evening shift. She was not aware the resident desired showers.

F 561

and Certified Nursing Aide's on the following:

- Residents have the right to receive showers according to their preference
- On admission residents are asked if they prefer to follow the facility shower schedule or do they wish to choose their own.
- On admission each resident will have their shower schedule entered into point click care to fire to the CNA's task for completion.
- It is very important that the shower schedule is followed. If the resident refuses the shower or bed bath, then this must be documented in PCC and the hall nurse must be notified of the refusal. Residents have the right to refuse and they also have the right to choose an alternate day or shift for their showers. We should always strive to accommodate the needs of the resident.
- If a resident desire to change their shower schedule then communicate this to the MDS nurse, DON, or any other Nurse Manager.
- The MDS nurse, DON or Unit Manager should then update the shower preference in PCC.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 561	Continued From page 4 On 12/19/24 at 12:29 pm NA #6 was interviewed. NA #6 stated she was assigned to Resident #62 on evening shift a couple of occasions. The NA asked the resident if she wanted a shower and the resident pointed to her leg and nodded her head yes to pain. NA #6 reported the resident's pain to the nurse. The resident refused once due to pain. NA #6 stated a shower would be given even if a resident had a bed bath the same day. NA #6 stated If an NA documented N/A or NO the shower was not given. On 12/19/24 at 2:40 pm NA #8 was interviewed. NA #8 stated that Resident #62 refused one shower. He also stated that he would offer a shower even if the resident had received a bed bath on the same day. Staff was required to offer. On 12/19/24 at 5:03 pm an interview was conducted with NA #2. NA #2 stated that she remembered Resident #62. She stated that if her documentation for the resident's Kardex in the kiosk was NO or N/A then the care was not provided.	F 561	in-service will be provided to all agency Nurses and Certified Nursing Aides who give residents care in the facility. As of 01/20/2025, any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or designee will monitor compliance utilizing the F561 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing/designee will monitor resident’s preference of shower’s, shower compliance and satisfaction with showers. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: January 20, 2025	
F 567 SS=B	Protection/Management of Personal Funds	F 567		1/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 567	Continued From page 5 CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do	F 567		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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

F 567

Continued From page 6

not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews of the resident, staff, and Department of Social Services, the facility failed to manage a resident's facility trust fund account when a billing discrepancy was discovered regarding the resident's patient monthly liability (PML) for February 2024. This deficient practice affected 1 of 1 resident reviewed for personal funds (Resident #24).

Findings included:

Resident #24 was admitted on 2/27/24.

Resident #24's RTF statement documented Resident #24 had a deduction from his Resident Trust Fund (RTF) for his February 2024 PML.

A document from the Department of Social Services (DSS), clarified the amount due to the facility for February 2024 skilled nursing was for the full month and was not prorated, as it should have been for 2 days, starting 2/27/24.

On 12/16/24 at 11:05 am Resident #24 was interviewed. He stated the facility charged over $600 from his skilled nursing facility (SNF) resident trust fund (RTF) account without notifying him back in April 2024. He noticed on his April 2024 RTF statement the money was withdrawn. The resident stated he notified the business office sometime in April 2024 of the error and he still had not been reimbursed. According to the resident, the business office member's answer repeatedly was they were

F 567

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F567
The facility failed to notify the resident when a billing discrepancy was discovered regarding the resident's patient monthly liability (PML) for February 2024. (Resident # 24)
1. Corrective action for resident(s) affected by the alleged deficient practice:

On 5/26/2024, BOM was notified there was a discrepancy in the monthly liability (PML) for Resident #24 for February 2024.
The Business Office Manager spoke to Resident #24 to inform and explain the discrepancy; the Resident had no concern at that time.
In July 2024, the resident expressed concerns regarding his PML and the Business Office Manager reached out to DSS to inquiry of the discrepancy in the PML (he was in assisted living until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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

F 567

Continued From page 7

working on it.

On 12/17/24 at 10:32 am an interview was conducted with the Business Office Manager. The Business Office Manager stated when Resident #24 moved from adult care to SNF care nursing on 2/27/24, he was billed for the entire month of February 2024 for skilled nursing PML instead of 2 days prorated. This mistake was not identified until April 2024 when the Business Officer Manager first started the position. The corporate business office was working on correcting the mistake since it was first identified in April. The resident complained to the Business Office Manager a couple of months after April that he was due money. The resident believed he was due approximately $600 from the "mistake." The error had not been corrected and the resident had still not been refunded. The Business Office Manager stated the Administrator was not made aware.

The Business Officer Manager provided a copy of an email to DSS staff dated 7/18/24 requesting an answer whether the facility should take the entire month's PML for February for the SNF stay from Resident #24 starting 2/27/24 for that time or partial? The DSS staff responded the facility could bill for the SNF stay from 2/27/24 to 5/31/24.

The Business Office Manager provided a copy of an email to the corporate billing office, dated 7/31/24, informing the office Resident #24's DSS case correction was completed. The corporate office could bill PML for 2/27/24 through 5/31/24 for his SNF stay.

On 12/17/24 at 11:53 am the Administrator was

F 567

02/26/24 and then transferred to Skilled Nursing for the remainder of the month.) According to the liability form he owed the facility and increase in pay. When he transferred over to SNF he had a credit which covered part of the PML and the resident gave permission to transfer the money from his trust account to the Business Office Manager to resolve the discrepancy. The Business Office Manager stated she sent an email in July 2024 to DSS following up asking if we should we have taken partial payment for the 3 days in February or the full amount and never received an email response of resolution.
On 12/17/2024 the Business Office Manager received an email from the DSS Case Manager regarding a billing discrepancy from February 2024. The Business Office Manager investigated the discrepancy and she was told that it was resolved (balance 0 PML).

On 01/14/2025, the Business Office Manager emailed DSS case worker to follow up with the PML discrepancy, waiting for the 5016 form to show 0 balance for the 3 days in questions. The DSS Case Manager informed 01/14/25 the system rejected the request due to the timeline of the inquiry. The DSS Case Manager informed the Business Office Manager that she needed to reprocess the request for payment for February 2024. Once the request is in the DSS system, the resident will have the credit applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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

F 567 Continued From page 8

interviewed. The Administrator stated she spoke to Resident #24 (on 12/17/24). The resident informed her money was owed to him and he had reported the concern to the Business Office Manager months ago. The Administrator stated she spoke to the Business Office Manager and corporate today (12/17/24). The facility was communicating via email regarding the billing discrepancy and money due to the resident but had not acted upon the reimbursement. The Administrator stated she was not aware the resident was owed money.

On 12/17/24 at 1:08 pm a second interview was conducted with the Business Office Manager. The Business Office Manager stated after review of the documentation of Resident #24's billing discrepancy, it was identified the resident had 2 days in skilled nursing February 2024 and DSS allowed charges for an entire month, not prorated. DSS provided documentation for the facility to charge for the entire month of February which was not discovered until 5/24/24. DSS was asked to correct their documentation for the facility to bill correctly for February on 12/17/24. The resident was owed approximately $700. The Business Office Manager stated she had not remembered the last date she had spoken to DSS to correct the billing so the facility could release the funds they were holding before today (12/17/24).

On 12/17/24 at 3:20 pm a phone interview was conducted with DSS Staff. DSS staff stated she was called today (12/17/24) by the facility Business Office Manager regarding Resident #24's PML for 2 days in February 2024 that he was charged for an entire month. The DSS staff member did not remember communicating on

F 567

On 01/14/2025, the Business Office Manager spoke with Resident #24 to inform him of the status of his PML account for February 2024. He had no concerns at that time.

The Business Office Manager will continue to monitor the situation weekly, until she receives the acceptance and resolution.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
Beginning on 01/17/2025, the Administrator began auditing all resident's that required monthly Liability (PML) reports. This audit was completed on 01/17/2025. There were no billing discrepancies noted.
3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 01/17/25 Administrator educated the Business Office Manager on the following:

- The Resident is to be notified if a billing discrepancy is discovered regarding the resident patient's monthly liability (PML).
- Review of the Financial Management Policy

This information has been integrated into the Business Office orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 567	Continued From page 9 7/31/24 with the facility Business Officer Manager regarding the PML that was coded for the full month when the timeframe was for 2 days. The DSS staff stated she reviewed her records and found that the State Office decided the PML to be billed for the full month amount. The DSS staff stated normally the amount would be prorated to the actual number of days. The DSS staff had not known why the PML came back as a full month and commented that her supervisor reviewed her work and approved of this amount before it was submitted to the facility. She further stated she could not pro-rate the days on her end, the supervisor would need to address this. On 12/17/24 at 3:30 pm an interview was conducted with the DSS Supervisor. She stated today (12/17/24) was the first time she was made aware by her staff that Resident #24 was charged PML for a full month instead of 2 days for February 2024. She further stated she was not aware and had not remembered the 7/31/24 email to her staff regarding the question from the facility Business Office Manager about the PML charges and that DSS staff was made aware of the mistake. The DSS Supervisor stated she would submit to "zero out" the PML for 2 days and if the system would not allow the change due to the age of several months, a correction by the State Office would be requested. She stated the paperwork was initiated today (12/17/24) and would be provided to the facility to reimburse the resident.	F 567	been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Administrator will monitor that the process is in compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: January 20, 2025	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		1/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 585	Continued From page 10	F 585		

grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 585	Continued From page 11 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 585	Continued From page 12 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interview of the resident and staff, the facility failed to complete and provide a written grievance when a resident reported an error on his facility trust fund account statement. This deficient practice affected 1 of 4 residents reviewed for grievances (Resident #24). Findings included: Resident #24 was admitted on 2/27/24 with the diagnosis of chronic obstructive pulmonary disease. On 12/16/24 at 11:05 am Resident #24 was interviewed. He stated that the facility took over $600 from his facility trust fund account without notifying him way back in April 2024. He noticed on his April 2024 statement the money was taken. The resident stated he notified the business office sometime in April 2024 of the error and he had not been reimbursed. The business office member had not completed a grievance and there was no resolution. On 12/17/24 at 10:32 am an interview was conducted with the Business Office Manager.	F 585	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F585 The facility failed to complete and provide a written grievance when a resident reported an error on his facility trust fund account statement (February 2024) for Resident #24. 1. Corrective action for resident(s) affected by the alleged deficient practice: On12/17/2024, the Social Worker documented Resident #24 concerns and complaints regarding this PML discrepancy in February 2024 on a grievance form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 585	Continued From page 13 She stated that back in April 2024 Resident #24 was billed for a second patient monthly liability for February 2024 in error. She also stated the resident reported this to the business office and a grievance was not completed and the Administrator was not notified. On 12/17/24 at 11:53 am the Administrator was interviewed. The Administrator stated she spoke to Resident #24 (12/17/24). The resident informed her money was owed to him and that he had reported the concern to the Business Office Manager months ago. The Administrator stated she spoke to the Business Office Manager and corporate to resolve the concern (12/17/24). The Administrator stated the Business Officer Manager had not completed a written grievance form when the concern was reported.	F 585	On 12/17/2024, the Business Office Manager and Social Worker had a meeting with Resident #24 to discuss the discrepancy and resolution. On 01/14/25, when the Business Office Manager received the email informing the facility of the denial and reapplication, the Social Worker and Business Office Manager met with Resident #24 to inform them of the new information of rejection of the request due to timeline issues and reprocessing of the request. The Business Office manager and Social Worker agreed to keep Resident #24 aware of the progress. Resident #24 did not voice any concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Beginning on 01/17/25 the Social Worker interviewed all current alert and oriented residents and residents who were their own responsible party for errors reported to the facility related to trust fund account statements. The audit was completed on 01/17/2025. There were no errors identified on their facility trust fund statements x 3 months. Beginning on 01/17/2025 the Social Worker interviewed the responsible parties of all current residents who were not alert and oriented for errors in facility trust fund account statements x 3 months. This audit was completed by 01/19/2025. There were no concerns of errors identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 585	Continued From page 14	F 585		

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 01/17/2025 the Social Worker Consultant provided education to the Social Worker, the education included:

- The Liberty Health and Rehab Grievance Policy and Procedure

This information has been integrated into the standard orientation training and in the required in-service refresher courses for the Social Worker and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:
The Administrator or designee will monitor compliance utilizing the F585 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The tool will monitor compliance with the grievance process. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with the grievance process. The weekly QA Meeting is attended by the Administrator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 585	Continued From page 15	F 585	Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: January 20, 2025	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessment in the area of feeding tubes for 1 of 23 residents reviewed for MDS accuracy (Resident #6). The findings included: Resident #6 was admitted to the facility on 01/08/24 with diagnoses which included Parkinson's disease. The quarterly MDS, dated 10/15/24, indicated Resident #6 was moderately cognitively impaired and had a feeding tube while at the facility. An interview was conducted with Nurse #5 on 12/17/24 at 12:12 P.M. Nurse #5 stated that Resident #6 did not have a feeding tube and had never had one while he was at the facility that she was aware of. An interview was conducted with the MDS Coordinator on 12/17/24 at 3:01 P.M. The MDS Coordinator explained Resident #6 did not have a	F 641	F-641 Accuracy of Assessments Corrective actions • Resident #6 Minimum data set annual assessment with Assessment Reference date of 10/15/2024 reviewed and identified as inaccurately coded as resident does not have feeding tube. Minimum data set assessment with Assessment reference date of 10/15/2024 was modified and corrected by the facility MDS Nurse on 12/17/2024 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents will be completed in order to identify if the following question was coded accurately	1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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

F 641 Continued From page 16

feeding tube. She further explained the nutrition section of Resident #6's 10/15/24 quarterly MDS assessment had been completed by the Assistant Dietary Manager.

An interview was conducted with the Assistant Dietary Manager on 12/18/24 at 12:15 P.M. The Assistant Dietary Manager explained she had mistakenly marked Resident #6 as having had a feeding tube on his 10/15/24 quarterly MDS assessment due to human error.

An interview was conducted with the Director of Nursing (DON) on 12/19/24 at 11:55 A.M. The DON stated it was her expectation that the MDS assessment was coded accurately.

F 641

on the Minimum data set assessment: K0520B- Feeding Tube (e.g., nasogastric or abdominal (PEG))

This audit will be completed by regional minimum data set consultant no later than 1/20/2025. Any resident who is identified as having inaccurate coding of the above question will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator or designee. Any necessary Minimum data set corrections will be completed no later than 1/20/2025.

Systemic Changes
By 1/20/2025, education will be completed by facility that includes the importance of thoroughly reviewing each resident’s medical record in order to ensure that the assessment is coded accurately. Special emphasis will be placed on coding Section K0520 of the Minimum data set assessment.
The MDS items need to be thoroughly reviewed for accuracy prior to electronically signing the questions of the assessment.
This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Administrator or designee will begin auditing 5 random recently completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 641	Continued From page 17	F 641	minimum data set assessments for accuracy in coding on the Minimum data set assessment for K0520B: feeding tube. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled “Accurate Coding of MDS Audit Tool”. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction: Administrator and/or Director of Nursing. Date of Compliance: January 20, 2025	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of	F 644		1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 644	Continued From page 18 care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) application for a resident with newly evident mental health diagnosis for 1 of 2 sampled residents reviewed for PASRR. (Resident #3) The findings included: The North Carolina Department of Health and Human Services (NCDHHS) PASRR determination letter dated 02/01/2023 revealed a level I screen and a PASRR number that remained valid for the individual's stay and no further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness. Resident #3 was readmitted to the facility on 02/26/2024 with diagnoses including vascular dementia, with psychotic disturbance. The quarterly Minimum Data Set (MDS) dated 10/04/2024 had Resident #3 coded as cognitively intact. A review of the diagnosis list revealed a diagnosis of bipolar II disorder, 04/11/2024.	F 644	F644 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F644 The facility failed to Complete a Level II Preadmission Screening and Resident Review (PASRR) following a newly diagnosed Mental Health Disorder. (Resident #3) 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/17/2024, the Social Worker submitted through NCMUST a Preadmission Screening and Resident Review (PASRR) for Resident # 3. It was submitted and accepted on 1/17/2024. 2. Corrective action for residents with the potential to be affected by the alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 644	Continued From page 19 An interview with the Social Worker (SW) was conducted on 12/17/2024 at 10:10 AM. The SW stated he oversaw submitting PASRRs for determinations and when a resident had a new mental health diagnosis the facility submitted a PASRR application for a level II screen. Resident #3 had a new mental health diagnosis since her first determination letter and a new PASRR application was supposed to be submitted when she was diagnosed with bipolar II disorder on 04/11/2024. A PASRR level II screen should have been submitted after the new diagnosis but wasn't due to an oversite. An interview with the Administrator was conducted on 12/17/2024 at 10:38 AM. The Administrator stated Resident #3 did have a negative PASRR level I and did have new mental health diagnoses. The SW who oversaw the PASRRs should have submitted a new PASRR application at the time of a new mental health diagnoses, but it was not done. The Administrator also stated the SW will work with psych closer to get the new diagnoses as it happens so he will not miss any PASRR screenings.	F 644	deficient practice. All residents in the facility have the potential to be affected On 01/17/2025, the Social Workers with the assistance of the Health Information Manager (HIM) completed 100 % audit of all residents who have had a new Mental Health diagnosis assigned to them x 3 month, in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new diagnosis of Mental Health Diagnosis. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/17/2025, the Administrator completed education with the facility Social Worker and Health Information Manager: The education included: Social Worker: • The PASRR assessment process and requirements for when a level II PASARR is to be completed. • The North Carolina PASSR Authorization Codes Health Information Manager: • Notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASAR. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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
F 644	Continued From page 20	F 644	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Social Worker or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Administrator will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: January 20, 2025	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the resident and staff, the facility failed to provide a dependent resident nail care (Resident #23). This deficient practice affected 1	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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

F 677

Continued From page 21
of 3 sampled residents.

Findings included:

Resident #23 was admitted to the facility on 8/22/23 with the diagnosis of adult failure to thrive.

The care plan for Resident #23 included an activity of daily living deficit. The intervention was for staff to provide bathing, dressing, and all personal care.

The quarterly Minimum Data Set dated 11/14/24 for Resident #23 documented her cognition was moderately impaired. She was able to make herself understood and understands. The resident required substantial assistance for bathing, dressing, and personal care.

On 12/16/24 at 12:30 pm Resident #23 was observed and interviewed. The resident was alert and able to clearly make her needs known. The resident stated she wanted her nails cleaned and trimmed; she could not do this by herself. The resident's nails were long, uneven, jagged, and had black soil underneath with more on the right hand than the left. The staff had not offered nail care, and she had not thought to ask. She has a bed bath each morning during weekdays.

On 12/16/24 at 1:22 pm an observation of incontinence care with Resident #23 and NA #5 was completed. The resident had long, uneven and jagged nails with black soil underneath. A concurrent interview was completed with NA #5. She stated she was the assigned NA and was only providing incontinent care and meal set up. The NA commented that the resident's nails were

F 677

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F677
The facility failed to clean and trim dependent resident's nails (Resident #23) for 1 of 3 residents reviewed for Nail Care.
1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #23, on 12/17/2024 nail care was provided and documented by the hall nurse.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

Beginning on 01/16/2025, the nurse manager began auditing all current residents for the need of nail care. This audit will be completed by 01/17/2025. Nail care was provided to those residents identified in need of nail care. No residents were identified to required nail care.

The Certified Nursing Assistants' were educated by the nurse manager on 01/14/2025 that nail care is to be provided during daily activities of daily living care and whenever necessary and documented when completed. The nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 677	Continued From page 22 cut during bathing, and the hospice NA was providing the bathing and would provide nail care. The NA observed the long, dirty nails and stated she had not offered the resident nail care today and had not known why. The NA stated she was aware the facility staff were responsible for cleaning and/or cutting the resident's nails. On 12/16/24 at 1:22 pm an interview was conducted with Nurse #2. He stated the facility NAs were responsible for nail care if the hospice NA had not provided nail care during bathing. On 12/19/24 at 11:50 am an interview was conducted with NA #7. She stated that the NAs were responsible for nail care which was completed during bathing or showers and when requested. On 12/19/24 at 1:40 pm an interview was conducted with the Administrator. The Administrator stated she was not aware Resident #23's nails needed care. The facility was responsible for nail care if not completed by hospice staff during bathing.	F 677	is to notified if the resident refuses. This education is ongoing and will be completed by 01/20/2025. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 01/14/25 the Director of Nurses/RN Manager began education to all full time, part time, and PRN Nurses and CNA's on the following: • Resident fingernails should be kept trimmed and clean. This includes cleaning underneath nails. • Finger nails should be inspected daily- ex: when bathing, showering or when doing head to assessment. • If a resident refuses nail care, document and notify the nurse. • Refusals for care are also to be care planned. Ex: resident refusal is continuing to occur. • You are expected to read each resident kardex in PCC before you provide care. This way you will provide the ordered care that is specific to the resident's needs. • You must document all care you provide. Remember if you don't document care then it is considered not done. • You are expected to complete 100% of your documentation daily. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	**1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301**

(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
F 677	Continued From page 23	F 677	in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. As of 01/20/2025 by nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will nail care compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: January 20, 2025	