STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345353**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/09/26 through 03/13/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F236A-H1.	E0000		03/26/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/09/26 through 03/13/26. Event ID# 1F236A-H1. The following intakes were investigated: 2797724, 2792083, 2748665, 2746705, 2742454, 2745044, 2737294, 2730534, 2749102, 2720956, 2716520, 2724606, 2712904, 2701995, 2696451, 2691407, 2693554, 2687490, 2687525, 2686567, 2678210, 2652713, 2649595, 2647632, 2651071, 2639033, 2637089, 2636673, 2626154, 2628303, 2619620, 2621871, 2620283, 2610923, 2610534, 2572028, 2568238, 872165, 872164, 872167, 872163, 872162, 872161, 872160, 872158, and 872156. 33 of the 92 complaint allegations resulted in deficiency. 19 of the 96 complaint allegation(s) resulted in deficiency.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her	F0584	1. Corrective Action Taken for the Resident(s) Affected •The resident bathroom identified by the surveyor was immediately deep cleaned using facility approved disinfectants to eliminate the urine odor, this started 3/09/2026, completed 3/10/2026. Environmental Staff Services staff completed this process. •The discolored flooring was scrubbed, sanitized, and treated, 3/10/2026 by environmental services. •The flooring was then scheduled for replacement, and this was completed prior to 3/13/2026 by external vendor. •The lower door frames were sanded, primed, and	04/10/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0584 SS = D	Continued from page 1 personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident, and staff interviews, the facility failed to maintain two bathroom floors and door frames in good repair and to ensure one of the bathrooms was free of odor which affected 3 residents (Resident #51, Resident #65, and Resident #10) on 1 of 3 halls reviewed for clean, comfortable and homelike environment (A hall). Findings included: 1a. On 3/9/26 at 3:45 PM an observation of the shared bathroom floor in Resident #51 and Resident #65's room, which was on the A hall, was conducted. A very strong odor of urine was noted upon entering the resident room. A grayish discoloration was noted on almost all	F0584	Continued from page 1 repainted with moisture resistant paint by vendor prior to end of day 3/13/2026. •The bathroom was returned to service only after verification by the Director of Environmental Services (EVS) by the Administrator on 3/13/2026. 2. How the Facility Identified Other Residents Who Could Be Affected •A facility wide audit of all resident bathrooms and common restrooms was completed 3/10/2026 by the Regional Director of Environmental Services to identify any similar odors, discoloration, or peeling paint. In total 3 bathrooms were identified: •Any areas showing concerns were immediately cleaned, repaired, or repainted by external vendor, all were completed by end of day 3/13/2026. 3. Measures Put in Place or Systemic Changes Made to Prevent Recurrence •EVS staff were re educated on bathroom cleaning protocols, including odor neutralization procedures and reporting of environmental concerns to the Administrator by the Regional Director of Environmental Services, this was completed on or before 3/13/2026. •Maintenance staff were re educated on early identification and reporting of moisture related damage, peeling paint, and flooring deterioration, this was completed by the Regional Director of Environmental Services on or before 3/13/2026. •An environmental inspection checklist was implemented for all bathrooms, requiring joint sign off by EVS and Maintenance. •A process was added requiring EVS staff to immediately notify Maintenance of any structural or cosmetic deterioration observed during routine cleaning. 4. How the Facility Will Monitor Its Corrective Actions to Ensure the Deficiency Does Not Recur The Director of Environmental Services or designee will conduct weekly inspections for 2 weeks of all resident bathrooms, then monthly for 3 months, and as needed thereafter. Inspection results will be documented and reviewed during monthly QAPI meetings. to include the Administrator, Director of Nursing, Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0584 SS = D	Continued from page 2 the cream Vinyl Composite Tile (VCT) flooring, especially at the edges of each square tile. The VCT appeared aged, scuffed, scratched, and had no evidence of finish or wax. The floor close to the base of the toilet was noted to be wet. The far-right corner floor from the bathroom door appeared to have three cut tile pieces placed on top of the original floor to patch it and did not create a smooth cleanable finish and edge. In addition, the bathroom door frame was noted to have multiple areas of peeling paint, exposing brown metal. A quarterly admission Minimum Data Set (MDS) assessment dated 2/13/26 coded Resident #51 as cognitively intact. An interview was conducted with Resident #51on 3/9/26 at 3:47 PM and he stated he did not use the bathroom because he was incontinent, but he could smell the odor from his bed which was by the window and was further from the bathroom door than the other bed in the same room. Resident #51 stated he did not like the smell at all because it was not pleasant. He further stated that he had not reported the issue to the facility staff because anyone who came to his room could smell it. The resident was unable to identify how long it had been since he first noticed the odor. An annual MDS dated 2/27/26 coded Resident #65 as cognitively intact. During an interview with Resident #65 on 3/10/26 at 2:56 PM he reported that he used the toilet in his room independently and when asked how he felt about the condition of the bathroom or how long the bathroom had smelled like that he said he did not know. During an interview on 3/10/26 at 1:05 PM with NA #4 she stated that Resident #65 used the toilet in his room all the time and she had noted the floor to be wet sometimes and had a bad smell. NA #4 further stated she did not report this to anyone because anyone that came to the room could smell the odor and see the condition of the bathroom floors. 1b. On 3/9/26 at 3:55 PM an observation of Resident #10's bathroom, which was on the A hall, was conducted. The bathroom floor, which consisted of cream colored VCT was noted to have black and gray discoloration on most of the floor. The VCT appeared aged, scuffed, scratched, and had no evidence of finish or wax. The lower portions of the bathroom door frames on both sides of the bathroom were noted to have paint peeling off exposing brown metal. A quarterly admission Minimum Data Set (MDS) assessment	F0584	Continued from page 2 Nurse/ADON, Social Worker, MDS Nurse, Health Information Manager, Unit Managers, Dietary Manager and Activity Director. Any deficiencies identified will result in immediate corrective action and staff retraining. The QAPI committee will evaluate trends and determine if additional interventions are needed. 5. Date of Compliance •The facility will be in compliance by 4/10/2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0584 SS = D	Continued from page 3 dated 12/25/25 coded Resident #10 as cognitively intact. An interview was conducted with Resident #10 on 3/10/26 at 12:48 PM she stated she used the bathroom in her room, but she did not like how it looked and it made her feel bad. She stated that housekeeping staff cleaned it and sometimes she tried to clean it too to make it look better. Resident #10 stated she had discussed the condition of the bathroom with the Administrator about 2 to 3 months ago and the Administrator had told her that the facility would try to “wax it and buff it to make it look better.” During an interview on 3/12/26 at 8:22 AM with Housekeeping Aide #1 she reported she worked 5 days a week and was assigned the resident rooms and bathrooms on the A hall. She further explained on the days she was not working; Housekeeping Aide #2 was assigned to clean A hall resident rooms and resident bathrooms. Housekeeping Aide #1 verbalized she had noted water on the floor and an odor in Resident #51 and Resident #65’s bathroom when she went in to clean the bathroom and that the Housekeeping Supervisor was aware. Attempts to interview Housekeeping Aide #2 were unsuccessful. During an interview on 3/10/26 at 12:58 PM with Regional Maintenance Manager he stated that the toilet (closet) flange (pipe fitting that connects the toilet to the drain line, secures it to the floor and seals out sewer gas using wax ring) in Resident #51’s room was broken. He explained that when the flange which was supposed to create a seal was broken it made the water back up when the toilet was flushed, the floor would get wet. He indicated it should have been fixed and that they were going to start working on it later that day. He stated he learned about the bathroom concern from the former Maintenance Director and facility Administrator but could not recall the exact dates. An interview was conducted on 3/11/26 at 2:05 PM with the Housekeeping Supervisor. He stated they had tried to clean the floors in Resident #51 and Resident #10’s bathrooms but the floor discoloration could not be solved by cleaning but needed replacement. He explained that they had tried a floor cleaning process that involved enzymes, scrubbing, and stripping to try and clean the bathroom floors, but it did not succeed in resolving the discoloration of the tiles. An observation of the door frames was conducted with the Housekeeping Supervisor during the interview. He stated that they were going to repaint the door frames when	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0584 SS = D	Continued from page 4 they fixed the bathroom floors. A follow up interview was conducted on 3/13/26 at 10:30 AM with the Housekeeping Supervisor and District Housekeeping Manager. They reported that water would sometimes seep up through the bathroom floor tiles in Resident #51 and Resident #65's bathrooms when someone stepped on the bathroom floor. During an interview on 3/10/26 at 2:10 PM with the Administrator she stated she was aware of the situation in Resident #10 and Resident #51/Resident #65's bathrooms since December 2025. She stated she noticed the bathroom floors were discolored when she was doing her rounds. The Administrator stated her expectation was the facility should have a plan to address any repairs and renovations that were needed to fix the bathroom floors and bathroom door frames. During a follow-up interview with the Administrator on 3/12/26 at 2:05 PM she verbalized that her expectation was for the facility to identify any environmental problems in the facility and address them. The Administrator added she thought one of the residents who used the bathroom in Resident #51's bathroom urinated on the floor which the facility staff would clean when they were aware that happened and they were working on replacing the bathroom floor tiles.	F0584		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident and staff, the facility failed to protect the residents' right to be free from misappropriation for 3 of 6 residents (Residents #60, #10, and #45) reviewed for misappropriation of property. Resident #60's Oxycodone (narcotic pain medication) was misappropriated and Resident #10's and Resident #45's Healthcare Spending Cards (health insurance cards with monthly monetary benefits that can be utilized for purchasing approved	F0602	1. Corrective action for the resident(s) found to be affected A. Resident #10 and #45: misappropriated their healthcare spending cards containing funds •Upon discovery that the Activity Assistant misappropriated (resident #10 and resident #45) residents' Healthcare spending cards containing funds, the Activity Assistant was immediately suspended pending investigation on 9/16/2025 and is currently no longer employed. •Administrator immediately ceased all staff assisting with online or in person shopping transactions on 9/16/2025 that require a staff member to utilize a resident's credit card, debit card, money, healthcare spending cards, checkbook, etc. •100% of residents were audited to ensure all with healthcare spending cards had no funds missing from those accounts, no further missing funds found related to healthcare spending cards, this was completed on or before 9/23/2025. No further concerns noted with healthcare spending cards.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 5 food items and over-the-counter products) were taken by the Activities Assistant without their knowledge and used for her own personal purchases. Findings included: The facility's abuse policy which was revised on 12/2024 was reviewed and the policy stated misappropriation was the deliberate misplacement, exploitation or wrongful use of the resident's money or belongings. The abuse policy further stated the residents have the right to be free of misappropriation of their property. 1. Resident #60 was admitted to the facility on 09/05/2025. A review of Resident #60's electronic medical record (EMR) revealed his physician's order of Oxycodone HCl 10 milligrams every 4 hours as needed for pain was initiated on 12/04/2025. A Packing Slip Proof of Delivery form from the facility's contracted pharmacy was provided for review by the facility. The form was not signed by a receiving nurse but indicated 180 tablets of Oxycodone 10 milligrams were delivered to the facility on 12/04/2025. An interview with Nurse #3 was conducted on 03/12/2026 at 10:32 AM. She worked from 7:00 AM to 7:00 PM on 12/21/2025. Around 6:30 PM she was at the nurse's station completing her paperwork when Nurse #4 walked up to her and stated she was her relief for the next shift. She told Nurse #4 that another nurse was scheduled, and she stated she had called out and she was her replacement. Nurse #4 was not familiar to her but that was not odd to her because they used a lot of agency nurses. Nurse #4 also stated she did not need a long report because she usually worked that hall and was familiar with the residents. They counted the cart to include Resident #60's Oxycodone 10 milligram tablets and narcotic sheets and there were 103 tablets left. She gave Nurse #4 the keys, the Nurse took possession of the cart and walked down the hall with the cart. She finished her documentation and left the facility. On 12/22/2025 she came in for her 7:00 AM to 7:00 PM shift and Nurse #5 stated that Resident #60 did not have any Oxycodone. Nurse #3 told Nurse #5 when she	F0602	Continued from page 5 •The facility reimbursed resident #10 and #45's resident trust fund for the missing healthcare spending card funds. B. Resident #60's Oxycodone (narcotic pain medication) was misappropriated. •Immediately upon discovery of the misappropriation, the Director of Nursing (DON) and Administrator ensured Resident #60's pain management needs were addressed. The attending physician was notified, and replacement medication was obtained per provider order to ensure no interruption in pain control. The resident was assessed for pain and any adverse effects related to the missing medication, and appropriate interventions were implemented and documented. 2. Corrective action for residents with the potential to be affected A. Resident #10 and #45: misappropriated their healthcare spending cards containing funds •A facility wide misappropriation interview was completed by Director of Social Services on 9/24/2025 with 2 additional concerns reported, determined to be unrelated to Activity Assistant. Resident interviews were held from September 2025 – February 2026 in order to identify any concerns related to charge cards/money misappropriation. •A Letter was mailed to 111 resident responsible parties and emergency contacts on 3/26/26. The letter reminded everyone of the importance of safeguarding personal belongings, monitoring credit card type statements regularly, and that Staff are not permitted to assist with the use of credit cards, United Healthcare cards, or other debit card transactions. In addition, the letter requested that any suspected fraudulent activity or missing items should be reported to the Administrator immediately. •This letter was hand delivered to residents by the Activity Director on 3/20/26. •This letter is posted at the front lobby guest register as of 4/3/26. B Resident #60's Oxycodone (narcotic pain medication) was misappropriated. •The DON or designee completed a facility wide audit of:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345353**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 6 left the evening prior there were 103 tablets. Nurse #3 indicated she did not count the cart with Nurse #5 and went to get the Director of Nursing (DON). Attempted three calls to Nurse #4 for an interview and left telephone voice messages but she did not return the telephone messages. Attempted three calls to Nurse #5 for an interview and left telephone voice messages but she did not return the telephone messages. A review of Nurse #5's statement dated 12/22/2025 revealed she was asked to switch carts and counted with Nurse #4. The count and numbers for narcotic medications matched with what she called out. However, she did not see any medications for Resident #60. During an interview with the Quality Assurance (QA) Nurse on 03/13/2026 at 11:22 AM she stated the DON was out sick and could not be reached by phone. The QA Nurse indicated she was a part of the investigation of the missing medications. she stated Nurse #4 had worked at the facility as an agency nurse but was not on the schedule on 12/21/2025. Nurse #4 counted medications with Nurse #3 on 12/21/2025 for the 7:00 PM to 7:00 AM shift and all the narcotic medications and narcotic sheets were accounted for. Nurse #4 complained of a stomachache and counted with Nurse #5 and left the facility within an hour of her having the cart. The morning of 12/22/2025 Nurse #3 reported that Nurse #5 stated Resident #60 did not have any narcotic medication, but when she left the previous evening there were 103 tablets. Nurse #5 stated she did count the narcotics with Nurse #4, and the medication and narcotic sheets were accounted for but there were no medications or narcotic sheets for Resident #60. The DON discovered the narcotics were missing with the narcotic sheets and an investigation began. They called the police and made the initial allegation report. They assessed Resident #60 and he was pain free and contacted the provider for an emergency prescription. Resident #60 did not miss any medications. The QA Nurse further stated they could not say for sure who took the missing narcotics, but it was missing and staff were educated. 2a. Resident #10 was admitted to the facility on 2/26/24.	F0602	Continued from page 6 •All residents receiving controlled substances •Medication Administration Records (MARs) •Narcotic count sheets •Medication storage areas No discrepancies were identified during the audit. Residents identified as potentially affected were assessed to ensure medications were administered as ordered and that no interruption in treatment occurred. Providers were notified as appropriate, and corrective actions were documented. 3. Systemic changes to prevent recurrence A. Resident #10 and #45: misappropriated their healthcare spending cards containing funds The facility revised and re educated staff on the Personal Property and Misappropriation Prevention Policy, emphasizing: oProhibition of staff access to resident financial cards or benefit accounts oReporting of suspected misappropriation oMisappropriation is a crime The City of Fayetteville Police Department came and conducted in-services to residents and staff on 1/30/26 to discuss strategies to reduce loss and misuse and preventing, the elder justice reporting requirements, and criminal aspects of theft, fraud and exploitation. The facility implemented a secure storage option for residents who choose to utilize. 100% of employees were educated regarding misappropriation of resident property, with emphasis that no employee is permitted to handle resident financial cards, and that misappropriation is a crime in which suspicious activity must be reported to the Administrator. The education was completed by the Administrator, Director of Nursing, and/or the Regional Vice President of Operations on or before 9/29/2025 and has continued to include new employees and agency staff. The Letter on misappropriation will be included in the New Resident folder and given to the resident/Family at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 7 Resident #10's quarterly Minimum Data Set (MDS) dated 6/5/25 revealed Resident #10 was cognitively intact. The facility's investigation report dated 9/23/25 completed by the Regional Vice President of Operations for an allegation of misappropriation of property for Resident #10 indicated the facility became aware of the allegation on 9/16/25 when the resident reported her Healthcare Spending Card was unable to be located. Law enforcement and Adult Protective Services were notified. The Activity Assistant was the accused staff member and she was terminated on 9/16/25. The investigational summary submitted with the investigation report revealed the facility substantiated the allegation of misappropriation of property and that the Healthcare Spending Card was used without the resident's awareness by the Activities Assistant. The resident stated the wallet was stored in the bottom drawer of her nightstand and the investigation indicated that when staff searched the resident's room, the Healthcare Spending Card could not be located. The resident's insurance provider confirmed the card had been used at a local retail store for a transaction of $95.00 on 9/15/25 at approximately 4:00 pm. The Activities Assistant reported the resident had given her permission to take and use the card to purchase items for the resident. The Activities Assistant stated she returned the card and cash to the resident, explaining that approximately $50.00 represented her portion of the items purchased on the card. Interview with the resident revealed that the resident denied giving the Activities Assistant permission to take or use the card and denied awareness that the Activities Assistant had possession of the card. The resident also denied having received $50.00 cash from the Activities Assistant. Resident #10 was interviewed on 3/12/2026 at 8:15 am. Resident #10 indicated she recalled the incident in September 2025 when her Healthcare Spending Card was utilized without her permission. She explained that in the past, the Activities Director and Activities Assistant helped her with shopping online for food and personal items using her Healthcare Spending Card. Resident #10 reported that she discovered on 9/16/25 that her card was missing and she reported the missing card to the Unit Manager #1. Resident #10 stated the Regional Vice President of Operations reported to her that the Activities Assistant took her Healthcare Spending Card and used the card at a local store, spending $95.00. Resident #10 reported that the Activities Assistant informed her on 9/16/25 the purchases were made because her (the Activities Assistant's) children were hungry. Resident #10 denied	F0602	Continued from page 7 time of admission starting 4/2/26. Residents that admitted between 3/20/26 and 4/2/26 will be given the letter on 4/3/26 and it was mailed to families on 4/3/26. •New hire orientation was updated to include enhanced training on financial exploitation prevention and will continue for all new hires and agency staff effective 3/30/2026. •The facility implemented a secure storage option for residents who choose to utilize. •New hire orientation was updated to include enhanced training on financial exploitation prevention and will continue for all new hires effective 4/10/2026. B. Resident #60's Oxycodone (narcotic pain medication) was misappropriated The facility reviewed practices related to controlled medication management and safeguarding resident property, including: •Re education of all licensed nurses, medication aides, and agency staff on controlled substance handling, counting procedures, documentation, and reporting requirements •Reinforcement of shift to shift narcotic counts with immediate reporting of discrepancies •Secure storage of narcotic medications with restricted access •Clear instruction on prompt reporting of suspected diversion or misappropriation •Review and reinforcement of the facility's policy on resident rights and misappropriation 4. Monitoring to ensure ongoing compliance A. Resident #10 and #45: misappropriated their healthcare spending cards containing funds •The Administrator or designee will conduct weekly audits for 4 weeks and then monthly for 2 months or until no longer deemed necessary to ensure: oNo staff are handling resident financial cards or benefit accounts oAny stored financial items are secured and accounted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 8 having received $50.00 cash from the Activities Assistant. Resident #10 stated she felt disappointed in the Activities Assistant and expressed concern that a similar incident could occur again. Resident #10 further stated the facility reimbursed the amount of the unauthorized purchase into her resident trust account. Unit Manager #1 was no longer employed by the facility and was unavailable for interview. b. Resident #45 was admitted to the facility on 5/9/24. Resident #45's quarterly Minimum Data Set (MDS) dated 9/16/25 revealed the resident was cognitively intact. An initial report dated 9/23/25 completed by the Regional Vice President of Operations for an allegation of misappropriation of property for Resident #45 indicated the facility became aware of the allegation on 9/23/25. Resident #45's Healthcare Spending Card was misplaced sometime around 9/4/25. When unable to be located, the card was cancelled and a new card was requested. On 9/23/25 transactions on the card were obtained and indicated the Healthcare Spending Card was used after it was identified as missing. The accused was noted to be a former employee (the Activities Assistant). The incident was reported to law enforcement. The investigation summary dated 9/23/25 related to the allegation of misappropriation of property for Resident #45 revealed that during the investigation into Resident #10's allegation of misappropriation of property the facility identified that Resident #45's Healthcare Spending Card had been used without the resident's permission. It was determined during the investigation that in-store transactions occurred on 8/12/25 in the amount of $106.06, 9/4/25 in the amount of $212.38, and on 9/8/25 in the amount of $18.57 using Resident #45's Healthcare Spending Card for a total of $337.01. Resident #45 was interviewed on 3/12/2026 at 8:36 am. Resident #45 stated that her Healthcare Spending Card had previously been misplaced and she reported the misplaced card to the Activities Assistant. She was unable to recall the date this occurred. Resident #45 stated the Activities Assistant helped her with canceling the misplaced Healthcare Spending Card and ordering a replacement card. Resident #45 reported Social Worker (SW) #2 explained to her that her card had previously been used for in-store purchases before and after the card was identified as misplaced.	F0602	Continued from page 8 for. oWill call 6 resident responsible parties for those who do not handle their own funds to ensure no concerns with missing funds. •Results of audits will be reviewed in monthly QAPI meetings. •Any identified concerns will result in immediate corrective action and retraining. B. Resident #60's Oxycodone (narcotic pain medication) was misappropriated •The DON or designee will conduct weekly audits for four (4) weeks, followed by monthly audits for two (2) months, which will include: •Review of controlled medication counts •Verification of accurate MAR documentation •Monitoring for discrepancies or variances •Confirmation of staff adherence to narcotic handling procedures Audit findings will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process. Any identified issues will result in immediate corrective action, including additional education or disciplinary action as indicated. The monthly QAPI meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Social Worker, Health Information Manager, and the Dietary Manager. 5. •The facility will be in compliance by: 4/10/2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 9 Resident #45 stated her Healthcare Spending Card had been used without her permission. Resident #45 indicated she never made any in-store purchases on the card. Resident #45 further indicated the last time she used her card for an on-line purchase was sometime in early September 2025 with the help of the Activities Assistant. Resident #45 further stated she was upset regarding the situation and felt the Activities Assistant should be held accountable for using her card without her permission. Resident #45 reported that because of the incident she kept her personal items secured in a lockbox and stated the key to the lockbox was kept around her neck. Resident #45 further stated the facility discontinued assisting residents with online shopping because of this incident and residents now participate in scheduled shopping trips outside the facility to obtain personal items. Resident #45 further stated the facility reimbursed the amount of the unauthorized purchases into her resident trust account. Multiple attempts were made to contact the Activities Assistant and were unsuccessful. The police reports for the misappropriation of property allegations that occurred in September 2025 for Residents #10 and #45 were requested but were not received during the survey. The police department was contacted via phone on 3/13/26 at 1:58 pm and an email address was given for the officer on record. A message via email was sent to the officer on 3/13/26 and no response was received. The Activities Director was interviewed on 3/12/2026 at 9:26 am. The Activities Director stated that residents previously participated in online shopping every Thursday, which was facilitated by the Activity Department. The Activities Director explained that the Activities Assistant used a tablet computer to assist residents with online shopping and purchases. The Activities Director stated that Healthcare Spending Card were not to be used unless the resident was present during the transaction. The Activities Director explained that the Activities Assistant would help the resident select items from the tablet computer that they wanted to purchase and pay for the items with the Healthcare Spending Card with the resident present. The Activities Director indicated after the incident related to the Activities Assistant using Resident #10's Healthcare Spending Card occurred, the Activities Assistant reported that she went to a store after hours for Resident #10 and had the resident's permission to use her Healthcare Spending Card. The Activities Director stated that Resident #10 later reported to the	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 10 Regional Vice President of Operations that she did not give the Activities Assistant permission to use her Healthcare Spending Card. The Activities Director stated the Activities Assistant also helped Resident #45 with online shopping but did not admit to her (the Activities Director) that she used Resident #45's Healthcare Spending Card. The Activities Director further stated that following the incident the facility discontinued the online shopping process. The Activities Director reported that residents now participated in scheduled shopping outings to local stores to purchase their own items. She further stated that residents who were unable to attend the outings would contact their responsible parties or representatives to assist them with obtaining personal items. The Activities Director explained the facility now provided personal lock boxes with their own key for the residents to store their Healthcare Spending Card, other credit/debit cards, personal items, and cash. A phone interview was conducted on 3/13/26 at 12:02 pm with the Business Office Manager. The Business Office Manager stated Resident #10 and Resident #45 were reimbursed for the money identified as not being spent for purchases by the facility. An interview was conducted on 3/12/26 at 10:15 am with the Regional Vice President of Operations, who was serving as the Interim Administrator at the time of the misappropriation of property allegations for Residents #10 and #45. The Regional Vice President of Operations explained she was made aware of the initial misappropriation of property allegation for Resident #10 by Unit Manager #1 on 9/16/25. She explained that she conducted the facility's investigation and during the investigation it was identified that Resident #45 also had an allegation of misappropriation of property related to the Activities Assistant utilizing the resident's Healthcare Spending Card. The Regional Vice President of Operations stated that law enforcement was notified on 9/16/25 for the incident involving Resident #10 and on 9/23/25 for the incident involving Resident #45. The Regional Vice President of Operations stated the police department informed her on 9/25/25 the cases for Resident #10 and Resident #45 would be linked and the Activities Assistant was charged with 3 felonies. The Regional Vice President of Operations further stated the Activities Assistant resigned via email on 9/16/25. She reported that a background check had been completed for the Activities Assistant prior to employment, and the facility had no prior concerns related to criminal activity. The Regional Vice President of Operations stated that the Activities Assistant should not have taken the Healthcare Spending	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345353**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0602 SS = D	Continued from page 11 Cards belonging to Resident #10 and Resident #45. The Regional Vice President of Operations stated each resident with Healthcare Spending Cards, cash, or other personal items were given a personal lock box to store their personal belongings with their own key after the incidents happened. The Regional Vice President of Operations further stated the Director of Social Services had a master key for the lock boxes secured in her office. During an interview conducted on 3/12/26 at 10:15 am, the Administrator stated her expectation was that all staff follow the facility's policy related to misappropriation of resident property. The facility provided a corrective action plan that was not accepted by the State Agency.	F0602		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject	F0641	1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #54's Minimum Data Set (MDS) for Assessment Reference Date of 1/29/2026 was modified and corrected on 3/11/26 by the Regional MDS Consultant to accurately reflect the resident's fall history during the specified lookback timeframe. The MDS was resubmitted and accepted into the state database on 3/12/26 in Batch #1545. Resident #100's Minimum Data Set (MDS) for Assessment Reference Date of 1/15/26 was modified and corrected on 3/27/26 by the Regional MDS Consultant to accurately reflect the resident's fall history during the specified lookback timeframe. The MDS was resubmitted and accepted into the state database on 3/27/26 in Batch #1555. Resident #6's Minimum Data Set (MDS) for Assessment Reference Date of 1/1/2026 was modified and corrected on 3/12/26 by the Regional MDS Consultant to reflect that the resident had not used a trunk restraint at any time during the lookback timeframe. The MDS was resubmitted and accepted into the state database on 3/13/26 in Batch #1547. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: The Regional MDS Consultant completed a 100% audit of all current residents to determine which residents have had a fall at any time during the past 3 months in order to ensure that J1900-Falls had been accurately coded on MDS assessments that have been completed since fall(s). The audit results are as follows for Audit	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0641 SS = D	Continued from page 12 to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of falls and restraints for 3 of 20 residents reviewed for MDS accuracy (Resident #54, #100, and #6). The findings included: Resident #54 was admitted into the facility on 12/22/25 with diagnosis of epilepsy. Resident #54's medical record indicated he had a fall with on 1/5/26 resident was observed on the floor sitting on his buttocks. A nursing progress note dated 1/11/26 specified Resident #54 was lying on his right side on a fall mat with no injury noted. A nursing progress note dated 1/14/26 revealed Resident #54 was seen trying to get up out of the wheelchair and slide to the ground on his buttocks with no injury noted. And a nursing progress note dated 1/17/26 revealed Resident #54 was observed on the floor beside his wheelchair but was unable to state what had happened with no injury noted. Resident #54's discharge MDS dated 1/29/26 specified since admission/entry or reentry or prior assessment the resident had no falls with no injury, 1 fall with injury and no falls with major injury. An interview was conducted on 3/10/26 at 9:50 AM with the MDS Coordinator who confirmed she completed Resident #54's discharge MDS. She indicated that she was aware Resident #54 had multiple falls and he continued to be a fall risk. A review of the discharge MDS dated 1/29/26 that indicated Resident #54 had no falls with no injury was reviewed with the MDS Coordinator and the MDS Coordinator revealed the discharge MDS was incorrectly coded for falls. She stated she was unsure of how the coding error occurred.	F0641	Continued from page 12 period, 12/25/25 – 3/26/26: •6 of 17 residents identified noted with MDS that reflected inaccurate coding of J1900-Falls. 3/1/26-3/26/26 - 13 of 13 falls listed (included 9 residents) noted as not having had an MDS completed since listed fall(s). oModification and correction completed for MDS assessment identified with inaccurate coding of J1900 by Regional MDS Consultant on 3/27/26 and re-submitted to CMS in Batch #1556. The Regional MDS Consultant completed a 100% audit of all current residents on 3/26/26 to ensure that P0100 – Restraints had been accurately coded on all MDS assessments completed during the past 3 months. The audit results are as follows: •0 residents identified as having order(s) for any type of restraint. •0 residents identified as having been coded for having restraint on MDS assessments completed during the past 3 months. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/27/26, the Regional MDS Consultant provided targeted education to the facility MDS Coordinator on accurate MDS coding practices, with emphasis on Section J1900 - Falls. This education included specific coding requirements and coding tips from Chapter 3 of the RAI manual with a focus on the importance of thoroughly reviewing the resident's medical record prior to coding the MDS assessment in order to determine whether or not they have had any falls during the specified ARD lookback period. This education also emphasized importance of carefully reviewing each fall in order to determine whether or not the resident had sustained any major or minor injuries or no injuries from each fall so that the MDS may be accurately coded. On 3/27/26, the Regional MDS Consultant provided targeted education to the facility MDS Coordinator on accurate MDS coding practices, with emphasis on Section P0100-Restraints. This education included specific coding requirements and coding tips from Chapter 3 of the RAI manual with a focus on the importance of thoroughly reviewing the resident's medical record prior to coding the MDS assessment in order to determine whether or not they have used any type of restraining device during the 7-day ARD lookback	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0641 SS = D	Continued from page 13 An interview conducted with the Administrator on 3/10/26 at 10:30 AM revealed she expected all MDS assessments to be accurate and timely. 2. Resident #100 was admitted into the facility on 1/9/2026 with diagnoses of cerebrovascular accident and muscle weakness. Resident #100's medical record indicated he had 2 falls on 1/12/26. A nursing progress note dated 1/12/26 at 9:00 AM revealed Resident #100 was observed on the floor sitting on his buttocks, the fall was witnessed, resident stated he was not hurt. Resident #100 stated he was trying to get out of bed there was no injury noted. On 1/12/26 at 2:45 PM a nursing progress note specified Resident #100 was observed lying on his back, the Resident stated he was trying to get out of the chair. There was no injury noted. Resident #100's admission Minimum Data Set (MDS) dated 1/15/26 indicated there had been no falls since admission. An interview was conducted on 3/10/26 at 9:50 AM with the MDS Coordinator who confirmed she had completed Resident #100's admission MDS. A review of the admission MDS dated 1/15/26 that indicated Resident #100 had no falls since admission was reviewed with the MDS Coordinator. The MDS Coordinator revealed the admission MDS was incorrectly coded for falls. She stated she was unsure of how the coding error occurred. An interview conducted with the Administrator on 3/10/26 at 10:30 AM revealed she expected all MDS assessments to be accurate and timely. 3. Resident #6 was admitted to the facility on 9/25/25 with diagnoses that included cerebral infarction and vascular dementia. Review of Resident #6's physician orders did not include orders for physical restraints. Resident #6's quarterly Minimum Data Set (MDS) assessment dated 1/1/26 revealed she was cognitively impaired. The MDS further revealed she was coded for a	F0641	Continued from page 13 period. 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 DON or designee will audit 5 random MDS assessments weekly for 2 weeks, then monthly for 2 months, focusing on accuracy of coding of Section J1900-Falls on MDS assessments. Results will be reviewed during the monthly Quality Assurance (QA) committee meetings composed of the Administrator, Director of Nursing, Social Worker, Dietary Director, MDS Nurse, Rehab Therapy Director, and Activities Director. Any discrepancies will be addressed through retraining and corrective action. The DON or designee will audit 5 random MDS assessments weekly for 2 weeks, then monthly for 2 months, focusing on accuracy of coding of Section P0100 – Restraints on MDS assessments. Results will be reviewed during the monthly Quality Assurance (QA) committee meetings composed of the Administrator, Director of Nursing, Social Worker, Dietary Director, MDS Coordinator, Rehab Therapy Director, Health Information Manager, Unit Support Nurses, Dietary Director, Social Worker, and Activities Director . Any discrepancies will be addressed through retraining and corrective action. 5. Compliance Date: 4/10/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0641 SS = D	Continued from page 14 trunk restraint used less than daily. During an interview on 3/11/26 at 12:33 PM with the MDS Coordinator, she stated Resident #6 did not have a restraint, as there were no restraints used in the facility. She further stated that indicating Resident #6 had a restraint on the MDS was an oversight on her part. In an interview with the Regional Nurse Consultant on 3/12/26 at 12:07 PM she stated her expectation was that the MDS should be coded correctly, but sometimes buttons were pushed inadvertently. An interview was conducted with the Administrator on 3/12/26 at 12:20 PM. She stated her expectation was that all MDS assessments were completed accurately.	F0641		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, contracted Transportation Aide, and Medical Director, the facility failed to reschedule an eye appointment for 1 of 3 residents reviewed for vision services (Resident #9). The findings included: Resident #9 was admitted to the facility on 3/11/25	F0685	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #9's Ophthalmology appointment was rescheduled for 05/01/2026. Nursing staff confirmed the new appointment date and time with the provider. Transportation services and staff accompaniment (sitter) have been arranged to ensure Resident #9 is able to attend the appointment as scheduled. Nursing will monitor completion of the appointment and document follow up care and provider recommendations in the medical record to ensure continuity of care. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4 / 3 /2026 the DON conducted a facility wide audit of all residents with documented vision-related diagnoses, ophthalmology referrals, or pending eye appointments within the past 12 months. This audit included a review of orders, appointment tracking logs, transportation schedules, and progress notes to ensure all necessary appointments were scheduled and completed. Any missed, canceled, or unscheduled appointments were immediately rescheduled, and appropriate notifications and documentation were completed. Identified residents were reviewed by nursing to determine if additional clinical follow up was indicated. As of 4 / 3 /2026 all residents were in compliance.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0685 SS = D	Continued from page 15 with the last readmission on 1/23/26. His diagnoses included type 2 diabetes, glaucoma, and coronary artery disease. A physician progress note dated 1/26/26 indicated that Resident #9 was being referred to an outpatient ophthalmologist due to bilateral eye burning. A physician order dated 1/27/26 indicated a referral to ophthalmology (a medical specialty that focuses on comprehensive eye and vision care) at an outpatient facility. A physician order dated 1/27/26 indicated Refresh Tears Ophthalmic Solution 0.5 %. Instill 1 drop in both eyes four times a day for dry eyes. A physician order dated 1/27/26 indicated Tylenol extra strength oral tablet 500 milligram (mg). Give 1 tablet by mouth every 8 hours as needed (PRN) for pain. A quarterly Minimum Data Set (MDS) assessment dated 1/29/26 revealed Resident #9 had moderate cognitive impairment. He was coded as having adequate vision and no corrective lenses. He was coded as not having had pain and had not received scheduled or as needed pain medication or non-medication intervention for pain. A patient transport requisition form completed by Medical Supplies Personnel indicated Resident #9 had an eye appointment at an outpatient office on 2/13/26 at 8:10 AM and was to be ready for transportation at 7:10 AM. An interview was conducted on 3/11/26 at 9:30 AM with the Transportation Aide from a contracted transportation company. She explained that she picked up Resident #9 on 2/13/26 from the facility and drove him to his eye appointment at an outpatient office. When they arrived at the outpatient office, the Transportation Aide signed Resident #9 in and left him there for his appointment. She stated that staff from the outpatient office called her approximately 15 minutes after she had left letting her know that she needed to come and pick up Resident #9 because he could not be seen by the provider without someone accompanying him. The Transportation Aide stated that she called the facility and asked if someone was going to sit with Resident #9 at the outpatient office for his appointment and she was informed (she could not recall who she had talked to over the phone) that there	F0685	Continued from page 15 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4 / 4 /2026 the Director of Nursing began education of all full time, part time, per diem, agency and staff nurses on the appointment process. Education focused on: •Adherence to the facility's appointment scheduling and tracking process •Timely communication of transportation needs to the contracted transportation company •Nursing responsibility to confirm appointments and transportation arrangements •The requirement to arrange staff accompaniment to external medical appointments when: oRequested by the physician, and/or oThe resident has a BIMS score greater than 12 Staff were instructed on proper documentation of appointment scheduling, transportation coordination, accompaniment arrangements, and follow up actions in the medical record. 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. Any staff who does not receive scheduled in-service training by 04/09/2026 will not be allowed to work until training has been completed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will conduct weekly audits for four (4) weeks, followed by monthly audits for two (2) months or until resolved, of residents with scheduled external appointments to ensure: •Appointments are scheduled and completed as ordered •Missed or canceled appointments are rescheduled timely •Documentation is complete and accurate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345353**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0685 SS = D	Continued from page 16 was no one who was going to accompany him. She explained that she drove back to the outpatient office to pick up Resident #9 to take him back to the facility. When the Transportation Aide arrived at the outpatient office, she was informed that Resident #9 was having a medical emergency and an ambulance had been called to transport him to the Emergency Department (ED). She notified the facility by phone that Resident #9 was being transferred to the hospital. The Transportation Aide verbalized that she picked Resident #9 later that day from the ED and took him back to the facility. A review of Resident #9's medical records revealed no evidence that Resident #9's eye appointment that was originally scheduled for 2/13/26 had been rescheduled. During an interview on 3/10/26 at 2:15 PM with Medical Supplies Personnel she stated that she kept a calendar and transportation requisition forms for all residents that had appointments, but she did not have any records of an upcoming scheduled eye appointment for Resident #9. The Medication Administration Records from 1/28/26 through 3/10/26 for Resident #9 indicated the following: - Refresh Tears were administered 4 times per day as ordered. - PRN Tylenol 500 mg was administered once on 2/12/26 at 5:51 PM for a pain level of 4 out of 10 (on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible). - Pain assessments were conducted on all three shifts (7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM) with a recorded pain level of 0 on all assessments aside from the 3:00 pm to 11:00 pm shift on 2/12/26 (when PRN Tylenol was administered). Attempts to engage Resident #9 in a conversation about his vision and eye appointments were unsuccessful on 3/9/26 at 1:12 PM and 3/13/26 at 9:30 AM. During an interview on 3/13/26 at 10:00 AM with the Unit Manager for the hall Resident #9 resided on, she stated that Resident #9 was transferred to the ED from the eye clinic on 2/13/26 due to a medical emergency and did not receive ophthalmology services on that day. The Unit Manager indicated that she had called the eye clinic to schedule Resident #9's appointment but she	F0685	Continued from page 16 Audit results will be reviewed in Quality Assurance and Performance Improvement (QAPI) meetings. Any identified trends or concerns will result in corrective actions, including additional staff education or process revision. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Nurse Managers, Social Worker, Activity Director, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/10/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0685 SS = D	Continued from page 17 could not recall the exact date of the call and that she was waiting for a call back and then she would reschedule the appointment. She stated that Resident #9 was not in any distress when he left the facility on 2/13/26, and she did not think he needed to be accompanied for the appointment. He had an order for eye drops four times a day for dry eyes and as needed Tylenol for pain which nurses administered as ordered and Resident #9 had not continued to complain of burning or pain in eyes. Attempts to interview the Director of Nursing (DON) who was out of the facility during the survey were unsuccessful. During an interview on 3/12/26 at 12:10 PM with the Medical Director she stated that she expected the facility to schedule residents for any specialty referrals she ordered and to reschedule any missed appointments to ensure residents received the medical services they needed. The Medical Director stated that she had referred Resident #9 to ophthalmology due to burning in both eyes and she had ordered eye drops to relieve the eye dryness and burning until he was seen by the ophthalmologist for specialized treatment. An interview was conducted on 3/12/26 at 2:05 PM with the Administrator. She stated that her expectation was for the facility to reschedule any residents' missed appointments in a timely manner and that the nursing staff that received the order or unit manager would schedule the appointments. The Administrator stated that the facility would send staff to accompany a resident who was not able to communicate their needs or if the doctor's office requested someone to accompany the resident. She further stated that if the facility thought that Resident #9 was not able to communicate his needs, they would have sent someone with him. She explained that the 2/13/26 appointment was Resident #9's first scheduled appointment at that ophthalmologist.	F0685		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F0686	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The cited resident is not a current resident in the facility. On 4/3/2026 the Director of Nursing (DON) reviewed new admissions within the last 7 days to ensure they had appropriate wound care orders that were being completed per MD order. The new admissions residents received comprehensive wound assessments, and a wound care plan	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0686 SS = D	Continued from page 18 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Wound Physician Assistant and Medical Director interviews the facility failed to initiate wound treatment for 4 days upon admission for a resident who was admitted with a pressure ulcer. This was for 1 of 3 residents reviewed for pressure ulcers (Resident #114). Findings included: Resident #114 was admitted to the facility on 4/24/25 with diagnoses that included type 2 diabetes and pressure ulcer of sacral region. An admission Minimum Data Set (MDS) assessment dated 4/30/25 indicated Resident #114 was cognitively severely impaired. She was dependent on staff with oral and personal hygiene, bathing/showers, rolling left and right in bed and transfers. She had impairment on both sides of the upper and lower extremities. She was coded for one unstageable pressure ulcer that was present on admission. An admission skin assessment dated 4/24/25 indicated pressure ulcer to sacral area was covered with clean dry dressing and no bleeding or drainage was noted on the dressing. The assessment did not include measurements of the wound. A review of Resident #114’s medical records did not reveal wound care orders or any documentation of sacral wound treatment on 4/25/25, 4/26/25, 4/27/25 and 4/28/25. A review of Resident #114’s April Treatment Administration Record (TAR) revealed an order dated 4/28/25 that indicated cleanse sacrum with wound cleanser and pat dry. Apply primary treatment of medical grade honey and cover with dry protective dressing every day shift for Stage 3 pressure injury. This treatment was checked on the TAR as completed on 4/29/25. The order was discontinued on 4/29/25.	F0686	Continued from page 18 was developed and incorporated into the resident’s care plan. No concerns were identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/3/2026 The DON or designee conducted a facility wide audit of all current residents admitted within the past thirty (30) days and all residents with existing pressure ulcers to ensure: •Comprehensive skin assessments were completed on admission •Wounds were accurately documented upon admission •Wound treatment orders were obtained and initiated timely There were no identified delays or omissions noted during the audit. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/ 4 /2026 The Director of Nurses began in-service of all licensed nurses to include agency nurses on the admission/wound care process to include: •Mandatory head to toe skin assessment completed and documented upon admission •Immediate notification of the provider and wound care team for any identified wounds •Requirement that wound treatment orders be obtained and initiated promptly upon admission •Implementation of a standardized wound admission checklist to ensure no delays in care •Education of all licensed nurses on admission wound assessments, wound documentation, provider notification, and timely initiation of treatment •Clarification of roles and responsibilities between nursing staff, wound care personnel, and providers The Medical Director reviewed and supported the admission wound process. The Director of Nursing will ensure that any staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0686 SS = D	Continued from page 19 A physician order dated 4/29/25 indicated consult wound care specialist to treat and evaluate Resident #114 as indicated for wound care. A physician order dated 4/29/25 indicated cleanse sacrum with wound cleanser and pat dry. Apply Santyl (topical enzyme medication) to wound bed and quarter strength [antimicrobial cleanser] moistened gauze and cover with dry protective dressing every day shift for unstageable pressure injury. This treatment was checked on the TAR as completed starting 4/29/25 onward. A review of the facility's standing orders last revised 6/25/24 had a section titled routine pressure ulcer care that indicated: (a) May treat stage 1 and 2 wounds and skin tears according to facility wound guide policy or nursing home policy recommendation. (b) Stage 3 and 4 wounds as ordered by medical doctor or wound care specialist. An interview was conducted with the former Wound Treatment Nurse on 3/11/26 at 1:15 PM. The Wound Treatment Nurse reported that she was not at the facility when Resident #114 was admitted to the facility. She explained that if a resident was admitted when she (Wound Treatment Nurse) was not at the facility the admitting nurse would complete a skin assessment, complete wound assessment, and implement orders from the discharge summary or standing orders and if there were no orders the admitting nurse would need to reach out to the provider to ask for wound care orders. Attempts to interview the nurse who had admitted Resident #114 to the facility on 4/24/25 were unsuccessful. An interview was conducted on 3/11/26 at 2:22 PM with the Corporate Nurse Consultant. She reported that she could not locate the orders implemented or the documentation indicating that Resident #114's sacral wound treatment was completed between 4/24/25 and 4/28/25 and so she could not say whether it was done or not and that she expected orders to have been implemented when Resident # 114 was admitted and treatment completed as ordered. During an interview on 3/11/26 at 3:45 PM with the Wound Physician Assistant (PA) he indicated that a different PA had completed Resident #114's initial wound evaluation on 4/29/25 and that he could give an overview based on the documentation. The PA reported that Resident#114's wound was evaluated weekly starting 4/29/25 by a wound provider during her stay at the	F0686	Continued from page 19 identified above will not be allowed to work as of 04 / 09/2026 until education is completed. 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. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nurses or designee will conduct weekly audits for four (4) weeks, followed by monthly audits for two (2) months, or until resolved of: •Newly admitted/readmitted residents •Residents with existing or newly identified wounds Audits will include review of admission skin assessments, wound treatment initiation, provider notification, and care plan updates for compliance with the pressure ulcer process. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Social Worker, Health Information Manager, and the Dietary Manager. ______________________________________ Include dates when corrective action will be completed 04/10/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER: Highland House Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0686 SS = D	Continued from page 20 facility. He stated that from the documentation in Resident #114's medical records there was no indication that the facility staff had reached out to the consulting company regarding Resident #114's wound care orders prior to the evaluation on 4/29/25. He further stated that there was no significant deterioration of Resident #114's wound when he compared the hospital wound measurements on 4/7/25 and the wound measurements completed by the former Wound PA on 4/29/25 at the facility. Resident #114's sacral wound measurements at the hospital on 4/7/25 were noted as follows: Length: 5 centimeters (cm), Width: 6 cm, Depth: 0.1 cm and size(area): 30 square centimeters. Resident #114's sacral wound measurements at the facility on 4/29/25 were noted as follows: Length: 4 centimeters (cm), Width: 8.4 cm, Depth: 0.4 cm and size(area): 33.6 square centimeters. During an interview on 3/12/26 at 12:10 PM with the Medical Director, she stated that she expected nurses to reach out to her if they did not have wound care orders in the discharge summary or if they could not use the standing orders to ensure that treatments were completed correctly. She stated that there was always a provider on call available 24 hours a day and that the nurse who admitted Resident #114 should have called when he realized the resident had a wound and there were no wound treatment orders. During an interview on 3/12/16 at 2:05 PM with the Administrator, she stated that she expected nurses to complete skin assessments on residents upon admission and contact the physician for wound care orders if there were no orders in the discharge documents or if they needed clarification.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F0689	1.1. Corrective action for the resident(s) found to be affected The cigarettes and lighter belonging to Resident #47 was confiscated and put back in the A hall smoking materials box on 3/10/26. The resident was re-educated by the RN Unit Manager on the smoking policy with a reminder that he was to ask for smoking materials from the A Hall desk and then to return the lighter and any unsmoked cigarettes back to the A hall nursing desk. On 3/13/26 Resident #47 was given the new smoking policy procedures for supervised smokers verbally and in writing which he signed. The Care Plan was updated on 3/10/26 to reflect that he was a supervised smoker. The Smoking Assessment was updated on 4/2/26. Resident	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345353**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	**1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0689 SS = D	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to secure smoking materials (cigarettes/lighters) for 1 of 3 residents reviewed for smoking (Resident #47). Findings included: Review of the facility resident smoking policy effective 02/2026 revealed that all resident smoking materials are maintained in a secure area (lock box) at the nursing station when not in use. Resident #47 was admitted to the facility on 12/27/2022 with diagnoses that included cerebral infarction (stroke) followed by hemiplegia, hemiparesis, aphasia and dysphagia, vascular dementia with mood disturbance and anxiety. The annual Minimum Data Set (MDS) dated 11/30/2025 revealed Resident #47 was cognitively intact. The MDS also indicated the resident required assistance with several activities of daily living, including eating (supervision/setup), upper body dressing (dependent), and required limited to extensive assistance for other self-care activities. The MDS further indicated he was coded for tobacco use. Review of smoking evaluation dated 03/02/2026 revealed Resident #47 was an independent, safe smoker and his preference to smoke independently at the times of his choice was honored. A observation of Resident #47 on 3/10/2026 at 12:19 PM revealed Resident #47 sitting in a day room eating candy. When asked if he had any smoking materials Resident #47 nodded yes and showed a lighter and two cigarettes rolled up in the bottom of his shirt. An interview with Nurse #1 on 03/10/2026 at 12:36 PM revealed she did not give Resident #47 any smoking materials. Nurse #1 stated she did not know where the cigarettes or the lighter came from. Nurse stated that she did not know the smoking policy as this was her first time working this hall. She stated that she normally worked on a different hall that did not have smokers. An interview with Nurse #2 on 03/10/2026 at 12:40 PM revealed that she worked with Resident #47 and was aware that he did not turn his lighter in once he finished smoking. She further stated that there were no	F0689	Continued from page 21 #47's family was notified verbally and in writing that smoking materials were to be brought directly to the A Hall nursing desk. As of 3/13/26 the resident is being supervised by the nursing staff while smoking; and his smoking materials are given to him in the designated smoking area and then confiscated by the nursing staff after he smokes. 2.Corrective action for residents with the potential to be affected There are two other grandfathered residents allowed to smoke by the facility. On 3/10/26 both residents were reminded of the smoking policy and smoking materials they had on their person were given to the Administrator. Both residents were told that they were in violation of the smoking policy. Both residents were given the new smoking policy procedures for supervised smokers verbally and in writing which both residents signed on 3/13/26. Both resident's Care Plan was updated on 3/10/26 to reflect that they had been designated as supervised smokers. Both resident's Smoking Assessment was updated on 4/2/26. As of 3/13/26 both residents are being supervised by the nursing staff while smoking; and their smoking materials are given to them in the designated smoking area and then confiscated by the nursing staff after they smoke. On 4/2/26 the families of both residents were notified verbally and in writing that smoking materials were to be brought directly to the A Hall nursing desk. On 4/1/26 all residents were given a letter from the Administrator reminding them that Highland House was a non-smoking facility and that they could not smoke or have smoking materials on the premises. This letter is posted at the reception area where guests sign in before visiting with residents. 3.Systemic changes to prevent recurrence The facility reviewed and revised the smoking policy to detail instructions to the residents and staff on how the facility will implement supervised smoking procedures for all three grandfathered smokers. This revision included supervision by the nursing staff during smoking times and their duty to distribute and collect smoking materials, and to ensure safety interventions identified for the smokers were followed. This policy revision was communicated and implemented on 3/13/26 to residents and staff. Education for the new smoking policy was initiated on 3/13/26 by the Administrator to all staff including our staffing agency and contract partners. Education included:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive , Fayetteville, North Carolina, 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
F0689 SS = D	Continued from page 22 designated smoking times and the smoking residents were allowed to smoke whenever they wished. She stated that this made it difficult for nursing staff to track when residents were smoking. Nurse #2 stated that once a resident returned from smoking, the resident was supposed to give their lighter and cigarettes to his or her nurse. Nurse #2 stated that she knew that this was not the case with Resident #47 as he liked to keep his lighter since he went out so frequently. Nurse #2 stated that the smoking materials were located in a lock box behind the nurses' station that any of the nursing staff could access. In an interview with Administrator on 03/10/2026 at 12:55 PM the Administrator stated that there were three residents grandfathered in who were allowed to smoke cigarettes in the designated area on facility property. Cigarettes were kept in a locked box at nurses' station at Hall A. Nurses were supposed to confiscate lighters after a resident finished smoking. She stated that she was not aware that residents were not turning in their lighters. She stated that residents may be keeping the lighters until they finish smoking for the day. When asked for clarification on if residents should turn in lighters at the end of the day or at the end of a smoking session, she stated that residents have been allowed to make that determination. She stated that some of the residents were hardcore smokers and they go out so often it is easier for them to keep track of the lighter rather than turn it in every time.	F0689	Continued from page 22 1)Identification of the 3 grandfathered smokers; 2)Location of smoking and the times the 3 grandfathered smokers could smoke; 3)Duties of nursing staff when supervising residents to include visually observing, distributing and collecting smoking materials; and where to put the smoking materials after smoking times. New-hires and new agency/contract staff will be given the education at orientation. 4.Monitoring to ensure ongoing compliance The Administrator or designee will conduct weekly audits for 2 weeks and then monthly for 3 months or until no longer deemed necessary to ensure: ð§Only grandfathered residents are smoking with supervision at designated times; ð§No smoking materials are kept on the resident's person or in their room. ð§Safety interventions are being followed per care plan and smoking assessments; and ð§Safety of designated smoking area. Results of audits will be reviewed in monthly QAPI meetings to include the Administrator, Director of Nursing, Staff Development Nurse/ADON, Health Information Manager, Unit Managers, Social Worker, MDS Nurse, Dietary Manager and Activity Director. Any identified concerns will result in immediate corrective action and retraining. 5. Date of Compliance •The facility will be in compliance by: 4/10/2026.	