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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive Fayetteville, NC 28301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 [DATE] 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 dated [DATE] 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 (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]. 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 [DATE]. 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 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE]. Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact. The facility's investigation report dated 9/23/25 completed by the Regional [NAME] 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 [NAME] 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 having received $50.00 cash from the Activities Assistant. Resident #10 stated she felt (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE]. Resident #45's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. An initial report dated 9/23/25 completed by the Regional [NAME] 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. 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Regional [NAME] 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 [NAME] 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 [NAME] 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 [NAME] 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 [NAME] 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 [NAME] 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 [NAME] President of Operations stated that the Activities Assistant should not have taken the Healthcare Spending Cards belonging to Resident #10 and Resident #45. The Regional [NAME] 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the incidents happened. The Regional [NAME] 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.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with the last readmission on [DATE]. 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 [DATE] 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 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 (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day. The Unit Manager indicated that she had called the eye clinic to schedule Resident #9's appointment but she 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 faciity 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Rehabilitation and Healthcare	1700 Pamalee Drive Fayetteville, NC 28301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included type 2 diabetes and pressure ulcer of sacral region.An admission Minimum Data Set (MDS) assessment dated [DATE] 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 [DATE] 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.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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 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.