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No. 0938-0391

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)

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

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 [DATE] 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. 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 [DATE] indicated there had been no falls (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 [DATE] 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 [DATE] revealed she was cognitively impaired. The MDS further revealed she was coded for a 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.

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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.