**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 345353

**Multiple Construction: A. Building: ___________________________**

**Name of Provider or Supplier:** Highland House Rehabilitation and Healthcare

**Street Address, City, State, Zip Code:** 1700 Pamalee Dr PO Box 35881 FAYETTEVILLE, NC 28301

**Date Survey Completed:** 10/25/2011

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider’s Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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No deficiencies were cited as a result of the complaint investigation on 10/25/11. Event ID IJ0211

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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 discloseable 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 discloseable 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.