**Statement of Deficiencies and Plan of Correction**

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

**Multiple Construction**

A. Building
B. Wing

**Completion Date:** 12/11/2013

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

**Street Address, City, State, Zip Code:** 1700 Pamelee Dr PO BOX 35881
Fayetteville, NC 28301

**ID Prefix Tag:**

<table>
<thead>
<tr>
<th>F 000</th>
<th>Initial Comments</th>
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<tbody>
<tr>
<td>F 000</td>
<td>No deficiencies were cited as a result of this investigation, Event MKE11.</td>
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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

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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 patient. (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.

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**Event ID:** MKE11

**Facility ID:** 923255