STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395826	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Hills Post Acute	1105 Perry Highway Pittsburgh, PA 15237

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy and clinical records and staff interviews it was determined that the facility failed to make certain controlled substances were accounted for accurately for four of seven residents (Resident R1, R2, R3, and R4). Findings include: Review of the facility policy, Administering Medications dated 11/1/24, indicated, Medications are administered in a safe and timely manner, and as prescribed. Review of the clinical record indicated Resident R1 was admitted to the facility 11/27/24. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 11/29/24, included diagnoses of emphysema (a lung disease which results in shortness of breath due to over-swelling of the alveoli) and lung cancer. Review of a physician order dated 12/6/24, discontinued 12/10/24, indicated Resident R1 was to receive oxycodone ER (extended release) 20 mg every twelve hours. Review of a physician order dated 12/6/24, discontinued 12/10/24, indicated Resident R1 was to receive oxycodone (an opioid pain medication) 5 mg, every four hours, as needed for pain. Review of the pharmacy shipping manifest dated 12/6/24, indicated at 5:20 p.m. Registered Nurse (RN) Employee E1 signed that 28 tablets of oxycodone 5 mg were received by the facility. Prescription number 7571023.00. Review of the pharmacy shipping manifest dated 12/7/24, indicated Licensed Practical Nurse (LPN) Employee E2 signed that 30 tablets of Oxycontin (trade name for oxycodone hydrochloride) ER (extended release) 20 mg were received by the facility. This document did not include a time the medication was signed for. Prescription number 7571278.00. Review of the December 2024 Medication Administration Record (MAR) indicated Resident R1 received Oxycodone ER 20 mg on: -12/7/24, 9:00 a.m. scheduled time. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/8/24, 9:00 a.m. scheduled time. -12/8/24, 9:00 p.m. scheduled time. -12/9/24, 9:00 a.m. scheduled time. Review of the December 2024 Medication Administration Record (MAR) indicated Resident R1 received Oxycodone 5 mg on: -12/6/24, 5:35 p.m. -12/6/24, 10:00 p.m. -12/7/24, 12:06 p.m. -12/7/24, 5:09 p.m. -12/8/24, 3:00 a.m. -12/9/24, 12:03 a.m. Review of a progress note dated 12/9/24, at 2:14 p.m. indicated Resident R1 was admitted to the hospital. Review of facility census information on 1/25/25, indicated Resident R1 did not return to the facility. On 1/25/25, the facility was requested to provide the controlled drug record (narcotic sign-out paper sheets that nurses sign each time a narcotic is administered) for Resident R1's oxycodone and oxycontin. During an interview on 1/25/25, at approximately 1:30 p.m. the Director of Nursing (DON) confirmed that she was unable to provide the narcotic sign-out sheets. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), history of a stroke, and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of a physician order dated 11/21/24, discontinued 1/13/25, indicated Resident R2 was to receive tramadol (an opioid pain medication) 50 mg, one time daily for pain. Review of a physician order dated 1/14/25, discontinued 1/15/25, indicated Resident R2 was to receive tramadol 50 mg, one time daily for pain. Review of a physician order dated 1/15/25, discontinued 1/20/25, indicated Resident R2 was to receive tramadol 50 mg, one time daily for pain, and one time in the evening for seven days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 1/20/25, indicated Resident R2 was to receive tramadol 50 mg, twice time daily for pain. Review of a physician order dated 11/20/24, indicated Resident R2 was to receive tramadol 50 mg, every eight hours, as needed for pain. Review of Resident R2's Controlled Drug Record for prescription number 7581806.00 indicated that additional doses of tramadol were signed out, without corresponding documentation of administration to the resident: -1/12/25, at 2:00 a.m. -1/14/25, at 12:30 a.m. Review of Resident R2's Controlled Drug Record for prescription number 7606865.00 indicated that additional doses of tramadol were signed out, without corresponding documentation of administration to the resident: -1/20/25, at 7:50 p.m. Additionally, review of both Controlled Drug Records (7581806.00 and 7606865.00) revealed that the administration for 1/13/25, at 9:00 a.m. was signed out on both records, with the tally showing one tablet removed for each. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and hemiplegia (paralysis on one side of the body). Review of a physician order dated 12/27/24, discontinued 1/1/21/25, indicated Resident R3 was to receive Norco (Hydrocodone-Acetaminophen, an opioid and Tylenol combination pain medication) 5-325 mg, every six hours as needed for severe pain. Review of a physician order dated 12/27/24, discontinued 1/1/21/25, indicated Resident R3 was to receive Norco 5-325 mg, every six hours as needed for pain. Review of Resident R3's Controlled Drug Records for prescription numbers 7589810.00, 7589810.01, and 7615405.00 indicated that additional doses of tramadol were signed out, without corresponding documentation of administration to the resident: -1/6/25, at 8:30 (a.m. or pm not listed) -1/7/25, at 2:30 a.m. -1/9/25, at 6:00 a.m. -1/9/25, at 6:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/10/25, at 12:00 p.m. -1/11/25, at 10:00 p.m. -1/12/25, at 6:00 a.m. -1/12/25, at 12:00 p.m. -1/13/25, at 6:00 a.m. -1/13/25, at 12:00 (a.m./p.m. not listed) -1/15/25, at 4:00 p.m. -1/16/25, at 9:00 (a.m./p.m. not listed) -1/17/25, at 10:00 a.m. -1/17/25, at 4:00 p.m. -1/18/25, at 12:00 N (noon) -1/18/25, at 9:00 p.m. -1/21/25, at what appeared to be a 9 (a.m./p.m. not listed) -1/22/25, at 2:55 p.m. -1/23/25, at 6:00 a.m. -1/23/25, at 12:00 p.m. -1/23/25, at 6:00 p.m. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE], after a left total knee replacement. Review of the facility diagnosis list included osteoarthritis and acute post-procedural pain. Review of a physician order dated 1/19/25, indicated Resident R4 was to receive one tablet of oxycodone 5 mg every four hours as needed for pain, and two tablets of oxycodone 5 mg every four hours as needed for severe pain. Review of Resident R4's Controlled Drug Records for prescription numbers 7610303.01 and 7610303.02 indicated that additional doses of were signed out, without corresponding documentation of administration to the resident: -1/20/25, at 4:00 p.m., two tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/20/25, at 9:00 p.m., two tablets. -1/21/25, at 1:45 a.m., two tablets. -1/21/25, at 10:45 p.m., two tablets. -1/22/25, at 2:09 p.m., two tablets. -1/22/25, at 10:00 p.m., two tablets. -1/24/25, at 1:36 p.m., two tablets, documented in the MAR as one tablet. During an interview on 1/25/20, at approximately 3:30 p.m. the NHA and the DON confirmed that the facility failed to make certain controlled substances were accounted for accurately for four of seven residents. 28 Pa. Code: 211.9(a)(1)(j) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.