

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2025
NAME OF PROVIDER OR SUPPLIER  Highland Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policies, clinical records, and facility provided documents, as well as staff interviews, it was determined that the facility failed to ensure that one of four residents (Resident R3) was free from abuse perpetrated by a resident with aggressive behaviors (Resident R1). Findings include: Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 11/1/24, indicated residents have the right to be free from abuse. This includes physical abuse. The prevention program consists of a facility wide commitment and resource allocation to support the following objectives: Protect residents from abuse by anyone including facility staff, other residents, etc. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Review of Resident R1's current care plan indicated a problem for behavior monitoring related to frustration and aggression. Goal of staff will monitor for changes in behavior and effectiveness of interventions. Interventions use diversional conversation, enjoys discussing hair dressing and salons, hair styles. Redirect resident when needed. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, and coronary artery disease (arteries that supply blood to the heart muscle become narrowed or blocked). Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of seven - severely impaired cognition. Review of Resident R3's current care plan indicated cognitive impairment, resident exhibits cognitive loss related to dementia. Goal of will improve current level of cognitive function as evidenced by ability to problems solve and ask for assistance with needs, locate room and respond to simple directions. Interventions included encourage routine daily decision making, reduce noise/distractions as indicated to provide a calm environment. Review of Resident R1's progress notes indicated the following:-5/11/25, at 10:48 p.m. nurse notified by NA that Resident R1 was in an unidentified females room. The female was trying to get Resident R1 out of the room, Resident R1 refused to leave and Resident R1 was hitting her and pushed her into the wall behind the door. Staff tried to intervene and were struck in the shoulder but then able to get Resident R1 out of the room. On every 15-minute checks.-5/15/25, at 3:24 p.m. eINTERACT form for providers indicated a change in condition related to behavioral status evaluation of physical aggression. Nursing observations, evaluation, and recommendations are to transfer Resident R1 to a room on the non-secured long-term care unit.-5/15/25, at 2:59 p.m. Resident was noted to be in the activity room at 1:45 p.m. and was noted by Nurse Aide (NA) to have a hold of Resident R3's left wrist and struck female resident on the back times two with a closed fist. Resident R1 was redirected away from the situation. Call placed to Resident R1's family to inform of the above. Also notified the provider who saw the resident. Review of Resident R3's progress notes dated 5/15/25, at 1:56 p.m. indicated Resident was struck in the back with a closed fist by Resident R1. Review of facility provided documentation dated 5/15/25, at 1:45 p.m. indicated staff witnessed Resident R3 being struck in the back with a closed fist, by another Resident R1 while attempting to walk past with the walker. No injury observed. Review of Nurse Aide (NA) Employee E13's witness statement dated 5/15/25, indicated when entering dining room, observed Resident R1 holding Resident R3 by the arm and hitting her in the back. Attempting to separate them Resident R1 hit Resident R3 again in the back. Resident R3 was seated into the chair and Resident R1 walked away like nothing had happened. Interview on 9/24/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that one of four residents (Resident R3) was free from abuse perpetrated by a resident with aggressive behaviors (Resident R1). 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of two allegations of abuse for two of three residents (Resident R1 and R3). Findings include: Review of facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 11/1/24, indicated all reports of resident abuse, neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Review of the clinical record and staff interviews indicated on 8/16/25, Resident R1 was found in the parking lot outside by the fire hydrant and was discovered by Resident R2 who alerted staff resident eloped. Review of the clinical record failed to include documentation of the event, notification to family, or physician was not completed as required. The facility failed to investigate the elopement and possibility of neglect, failed to report it as required not implementing written policies and procedures to ensure a complete and thorough investigation. Interview on 9/22/25, at 11:25 a.m. Nurse Aide (NA) Employee E4 indicated Resident R1 went out the door down the hall by room [ROOM NUMBER]. It's an emergency door. Staff are not to use that door, only central supply and maintenance get deliveries through there. They were bringing supplies in through that door for the carnival. NA Employee E5 had to go out and get resident in the parking lot. Interview on 9/22/24, at 11:35 a.m. Resident R2 indicated I'm the one that saw Resident R1 go out. Resident R1 was always trying to get out that door. A lot of the residents do, that are, you know, confused. I try to explain to them the best I can that they can't go out the door. I heard the door open just outside my room, looked out the window and saw Resident R1 in the parking lot walking towards the street by the fire hydrant. When I went in the hallway the door was still partially open, but I was afraid to go out to get Resident R1 because resident can have a temper, so I went to the nurses station, nobody was there, until finally a NA came into the hall and I screamed for help, Resident R1 is outside in the parking lot. Per Resident R2, Resident R1 leaned on the door, and it just opened, it wasn't locked. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, and coronary artery disease (arteries that supply blood to the heart muscle become narrowed or blocked). Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of seven - severely impaired cognition. Review of facility provided documentation indicated two witness statements were completed, and the physical abuse was not reported as required, and the facility failed to implement written policies and procedures for abuse. Review of Resident R3's progress notes dated 5/15/25, at 1:56 p.m. indicated Resident was struck in the back with a closed fist by Resident R1. Review of facility provided documentation dated 5/15/25, at 1:45 p.m. indicated staff witnessed Resident R3 being struck in the back with a closed fist, by another Resident R1 while attempting to walk past with the walker. No injury observed. Review of Nurse Aide (NA) Employee E13's witness statement dated 5/15/25, indicated when entering dining room, observed Resident R1 holding Resident R3 by the arm and hitting her in the back. Attempting to separate them Resident R1 hit Resident R3 again in the back. Resident R3 was seated into the chair and Resident R1 walked away like nothing had happened. Interview on 9/24/25, at 1:00 p.m. the Director of Nursing confirmed the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of two allegations of abuse for two of three residents (Resident R1 and R3). 28. Pa Code 201.14(a) Responsibility of licensee.28. Pa Code 201.18(b)(1)(e)(1) Management.28. Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, resident clinical records, incident reports, reports submitted to the State, and staff interview it was determined that the facility failed to report an allegation of abuse for two of three residents (Resident R1, and R3). Findings include: Review of facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 11/1/24, indicated all reports of resident abuse, neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Review of the clinical record and staff interviews indicated on 8/16/25, Resident R1 was found in the parking lot outside by the fire hydrant and was discovered by Resident R2 who alerted staff resident eloped. Review of the clinical record failed to include documentation of the event, notification to family, or physician was not completed as required. The facility failed to investigate the elopement and possibility of neglect, failed to report it as required. Interview on 9/22/25, at 11:25 a.m. Nurse Aide (NA) Employee E4 indicated Resident R1 went out the door down the hall by room [ROOM NUMBER]. It's an emergency door. Staff are not to use that door, only central supply and maintenance get deliveries through there. They were bringing supplies in through that door for the carnival. NA Employee E5 had to go out and get resident in the parking lot. Interview on 9/22/24, at 11:35 a.m. Resident R2 indicated I'm the one that saw Resident R1 go out. Resident R1 was always trying to get out that door. A lot of the residents do, that are, you know, confused. I try to explain to them the best I can that they can't go out the door. I heard the door open just outside my room, looked out the window and saw Resident R1 in the parking lot walking towards the street by the fire hydrant. When I went in the hallway the door was still partially open, but I was afraid to go out to get Resident R1 because resident can have a temper, so I went to the nurses station, nobody was there, until finally a NA came into the hall and I screamed for help, Resident R1 is outside in the parking lot. Per Resident R2, Resident R1 leaned on the door, and it just opened, it wasn't locked. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, and coronary artery disease (arteries that supply blood to the heart muscle become narrowed or blocked). Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of seven - severely impaired cognition. Review of facility provided documentation indicated two witness statements were completed, and the physical abuse was not reported as required. Review of Resident R3's progress notes dated 5/15/25, at 1:56 p.m. indicated Resident was struck in the back with a closed fist by Resident R1. Review of facility provided documentation dated 5/15/25, at 1:45 p.m. indicated staff witnessed Resident R3 being struck in the back with a closed fist, by another Resident R1 while attempting to walk past with the walker. No injury observed. Review of Nurse Aide (NA) Employee E13's witness statement dated 5/15/25, indicated when entering dining room, observed Resident R1 holding Resident R3 by the arm and hitting her in the back. Attempting to separate them Resident R1 hit Resident R3 again in the back. Resident R3 was seated into the chair and Resident R1 walked away like nothing had happened. Interview on 9/24/25, at 2:00 p.m. the Director of Nursing indicated the Administrator was aware of the elopement on 8/16/25, involving Resident R1, and that it was not reported as required; and indicated the resident-to-resident abuse was not reported as required involving Resident R1 and Resident R3. 28 Pa Code: 201.14 (a)(c)(e) Responsibility of management 28 Pa Code: 201.18 (b)(1) (e)(1) Management.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an elopement and possibility of neglect for one of three residents (Resident R1). Findings include: Review of facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 11/1/24, indicated all reports of resident abuse, neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Review of the clinical record and staff interviews indicated on 8/16/25, Resident R1 was found in the parking lot outside by the fire hydrant and was discovered by Resident R2 who alerted staff resident eloped. Review of the clinical record failed to include documentation of the event, notification to family, or physician was not completed as required. The facility failed to investigate the elopement and possibility of neglect, failed to report it as required. Interview on 9/22/25, at 11:25 a.m. Nurse Aide (NA) Employee E4 indicated Resident R1 went out the door down the hall by room [ROOM NUMBER]. It's an emergency door. Staff is not to use that door, only central supply and maintenance get deliveries through there. They were bringing supplies in through that door for the carnival. NA Employee E5 had to go out and get resident in the parking lot. Interview on 9/22/24, at 11:35 a.m. Resident R2 indicated I'm the one that saw Resident R1 go out. Resident R1 was always trying to get out that door. A lot of the residents do, that are, you know confused. I try to explain to them the best I can that they can't go out the door. I heard the door open just outside my room, looked out the window and saw Resident R1 in the parking lot walking towards the street by the fire hydrant. When I went in the hallway the door was still partially open but I was afraid to go out to get Resident R1 because resident can have a temper, so I went to the nurses station, nobody was there, until finally a NA came into the hall and I screamed help, Resident R1 is outside in the parking lot. Per Resident R2, Resident R1 leaned on the door and it just opened, it wasn't locked. Interview on 9/24/25, at 2:00 p.m. the Director of Nursing indicated the Administrator was aware of the elopement on 8/16/25, involving Resident R1, and could not provide an investigation on the event, confirming that the facility failed to conduct a thorough investigation of an elopement and possibility of neglect for one of three residents (Resident R1). 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights. 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for one of four residents (Resident R4). Findings include: Review of facility policy Assistive Devices and Equipment dated 11/1/24, indicated the facility maintains and supervises the use of assistive devices and equipment for residents. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/1/25, indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and aphasia (difficulty with either language or speech). Observation on 9/24/25, at 9:05 a.m. Resident R4 was observed in bed. A hand splint was noted in the bedside stand. Resident R4 had no splints on either hand. Interview on 9/24/25, at 2:00 p.m. Director of Rehabilitation Employee E12 indicated Resident R4 was discharged from therapy last on 9/4/25, to the Rehab Restorative transition program and a right resting hand splint (device to hold the hand in a functional resting position) on in the evening and off in the morning. Review of Rehab Restorative Transition Program document for Resident R4, provided by Director of Rehabilitation Employee E12, indicated right resting hand splint on in the evening and off in the morning. Review of Resident R4's current physician orders on 9/23/25, failed to indicate an order for use of a right resting hand splint. Review of Resident R4's current care plan on 9/24/25, failed to indicate a plan of care for use of a right resting hand splint. Interview on 9/24/25, at 2:16 p.m. the Director of Nursing confirmed the failure to process the Rehab Restorative Transition Program recommendations and indicated the facility is working on the processes for when a resident transfers from rehab to a long term care unit, and that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for one of four residents (Resident R4). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). This failure created an immediate jeopardy situation for one of twelve residents (Resident R1) identified as having a high risk for wandering. Findings include: Review of the facility policy Wandering and Elopements dated 11/1/24, indicated if identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. -If a resident is missing, initiate the elopement/ missing resident procedure;-If the resident was not authorized to leave, initiate a search of the building and premises;-When the resident returns to the facility, the Director of Nursing or Charge nurse shall:a. Examine the resident for injuries;b. Contact the attending physician and report findings and conditions of the resident;c. Notify the resident's legal representative;d. Notify search teams that the resident has been located;e. Complete and file an incident report; and f. Document relevant information in the resident's medical record. Review of the facility policy Accidents and Incidents - Investigating and Reporting dated 11/1/24, indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. -The nurse supervisor/charge nurse and/or department director of supervisor shall promptly initiate and document investigation of the accident or incident.-The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of the Incident/Accident form and submit the original to the Director of Nursing services within 24 hours of the incident or accident. - The Director of Nursing services shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. Review of the facility policy Care Plans, Comprehensive Person-Centered dated 11/1/24, indicated assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Section GG0170 Mobility indicated Section K. Walk 150 feet in a corridor or similar place was independent. Review of Resident R1's Elopement evaluation, upon admission, dated 8/4/24, indicated the following:-History of elopement while at home: No.-Does the resident have a history of elopement or attempted leaving the facility without informing staff: No.-Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No.-Does the resident wander: Yes-Is the wandering behavior a pattern, goal directed: Yes.-Does the resident wander aimlessly or non-goal directed: No.-Is the resident's wandering behavior likely to affect the safety or well-being of self/others: Yes.-Is the resident's wandering behavior likely to affect the privacy of others: Yes.-Has the resident been recently admitted or re-admitted (within the past 30 days) and is not accepting the situation: No.-Score of one or higher indicates risk of elopement-Risk for wandering/elopement identified: blank. Review of Resident R1's only other Elopement evaluation since admission, entitled Elopement and wandering risk observation/assessment dated [DATE], indicated the following instructions:-Evaluate/Assess the resident status in the seven clinical area listed below. If the total score is ten or greater, the resident would be considered at risk for wandering or elopement. Interventions implemented as determined by the facility Interdisciplinary team (IDT).-A. Mobility Status 4. Does the resident ambulate independently with or without the use of an assistive device? Yes.-B. Cognitive Status 2. Is the resident disoriented or has periods of confusion and/or impaired attention span but does not wander? Yes.-C. Disease Diagnosis: does the resident have a diagnosis that may impact cognition? 4. Two or more are present? Yes-D. Mood/Behavior Status: None-E. Medication: Does the resident take any medications that could increase restlessness or agitation? 4. Takes two or more medications? Yes.-F. History of Elopement Attempts: None-G. Behavior Modification 4. Exhibits unsafe wandering or elopement attempts and is difficult to redirect? Yes.-H Other relevant information-Communication - does the resident have any communication hearing or vision deficits?</p>		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical records and staff interviews, it was determined that the facility failed to provide sufficient and timely social services related to assistance in transferring to the Veterans Affairs (VA) for a behavioral bed for one of twelve residents (Resident R1). Findings include: Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/18/25, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and insomnia (persistent problems falling and staying asleep) Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of eight - moderately impaired cognition. Section GG0170 Mobility indicated Section K. Walk 150 feet in a corridor or similar place was independent. Review of Resident R1's census documentation record, Resident R1 Resided on the secured dementia unit from admission on [DATE], until being transferred to a non-secured long-term care unit on 5/15/25. Review of Resident R1's progress notes indicated the following:-5/15/25, at 3:24 p.m. eINTERACT form for providers indicated a change in condition related to behavioral status evaluation of physical aggression. Nursing observations, evaluation, and recommendations are to transfer Resident R1 to a room on the non-secured long-term care unit.-5/15/25, at 2:59 p.m. Resident was noted to be in the activity room at 1:45 p.m. and was noted by Nurse Aide (NA) to have a hold of a female residents left wrist and struck female resident on the back times two with a closed fist. Resident R1 was redirected away from the situation. Call placed to Resident R1's family to inform of the above. Also notified the provider who saw the resident.-5/15/25, at 4:13 p.m. Resident R1 was noted to have no further behaviors and 15-minute checks initiated. Resident R1 was transferred to long-term care unit with all meds and belongings. Report given to the nurse on the unit.-5/15/25, at 10:00 p.m. Resident R1 had taken some empty pill packets off of med cart and was attempting to take more. When redirected, resident grabbed bag on cart and ripped it; then hit the other nurse in the hand two times with a closed fist. Resident was then asked to return to their room. This writer had shown resident where the new room was, and then resident went in and went to bed with no further issues.-5/15/25, at 11:57 p.m. Resident R1 is alert with confusion. Resident wandering to unit and to other residents' rooms. Becomes combative when told not to touch a bag. Resident redirected after.-5/17/25, at 11:01 p.m. staff reported that resident was going into other residents' rooms and stealing their things. Redirection was attempted and explained those were not resident's belongings and needed to be returned to the owners. Resident said F*** you b*tch, these shoes are classy for you because you are a f*ng whore. The items were eventually returned to the rightful owners. Resident was aggressively charging staff. Ended up hitting staff on the left side of the face, was asked to stop, and hit staff again. Once staff tried to ask resident to please stop, resident hit staff for a third time. Staff was protecting two residents behind them, was scared for their life and pushed Resident R1 out of the way who ended up staggering back and fell to the floor. Staff ran from the room. Resident was assessed and reported no injury or pain.5/18/25, at 9:31 a.m. social services note indicated SW contacted the VA to inquire for services through the VA. emergency room nurse indicated that Resident is eligible for services through the VA. The VA social worker did indicate that they have many behavioral beds. 911 was called to take resident to the VA to have an x-ray and possible 302.-5/18/25, at 9:39 a.m. Resident R1 shows a pattern of behaviors of swearing and threatening residents as well as staff. He is also hitting staff and going into residents' room. SW did follow the EMS transportation to VA hospital ER in Oakland. The VA did place resident in a behavior emergency room to ensure staff could watch closely. X-rays were negative for fractures. Facility social worker met with Social Worker at VA to see if resident could be admitted under a 201, a voluntary commitment as the 302 could not happen as we had no witness to petition resident this day. -5/18/25, at 9:56 p.m. Resident R1 was swearing and threatening to harm nurse. Emergency medical services, whom just returned resident from the VA Hospital, were still waiting outside the resident's room. They stated that the VA could not 302 him earlier today because no one showed up to petition the 302. Contacted DON and Administrator and was instructed to call Resolve Crisis Center. Resolve Crisis Center contacted, and they will send a team to the facility as soon as they are able to.-5/18/25, at 11:29 p.m. resident was attempting to enter other residents' rooms when redirected he responded, Well screw you too, I'll have you thrown out of here -5/19/25 at 2:11 p.m. eINTERACT form indicated behavioral status evaluation for physical aggression</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on a review of a job description, facility and clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) did not effectively manage the facility to make certain that proper supervision was provided for residents at high risk for elopement as required, resulting in a resident elopement creating an immediate jeopardy situation. Findings include: The job description for the NHA specified the primary purpose of the job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Based on the findings in this report that identified that the facility failed to effectively manage the facility to make certain that proper supervision was provided for residents at high risk for elopement as required, resulting in a resident elopement creating an immediate jeopardy situation. The facility failed to provide fundamental principal that apply to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and facility policies. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(b)(1)(e)(1) Management.</p>		

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<p>F 0844</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel.</p> <p>Based on a review of regulations, documents submitted to the State agency and staff interviews it was determined that the facility failed to notify the State agency of a change in the facility's Nursing Home Administrator (NHA) at the time of the change. Findings include: Review of the facility's password agreement document dated 9/16/25, indicated NHA became the Interim Administrator effective 9/5/25, and that they are responsible for submitting a Plan of Correction in response to deficiencies cited by the Pennsylvania Department of Health on CMS Form 2567. During an interview on 9/22/25, at 9:00 am the Director of Nursing confirmed that NHA Employee E14 was on leave and that the administrator for the facility was the Interim NHA. During an interview on 9/22/25, at 9:00 a.m. the Director of Nursing confirmed that on 9/5/25, the facility failed to notify by written letter the State Agency of the change of administrators which failed to meet the requirement of notification at the time of the change. PA Code: 201.14(a) Responsibility of licensee.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>Based on review of facility files and an interview with the Human Resources Director Employee E9, it was determined that the facility failed to employ a full-time qualified social worker from 7/27/25, through 9/2/25. Findings include: Review of facility provided payroll documentation on 9/25/25, at 10:00 a.m. Social Worker Employee E10's last day worked was 7/27/25. Review of facility provided payroll documentation on 9/25/25, at 10:00 a.m. Social Worker Employee E11's first day worked was 9/2/25. Interview with the Human Resources Director Employee E9 on 9/24/25, at 10:05 a.m. confirmed that the facility failed to employ a full time qualified social worker from 7/27/25, through 9/2/25. Pa Code 211.16. Social Services. Pa Code 201.14 (a)Responsibility of licensee.</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide training on effective communication for two of five staff members (Nurse Aide (NA) Employee E15, and NA Employee E5). Findings include: Review of facility provided documents and training records for NA Employees E15 and NA Employee E5, failed to include education on effective communication as required. Telephonic interview on 9/25/25, at 9:52 a.m. Human Resource Employee E9 confirmed that the facility failed to provide training on effective communication for two of five staff members (NA Employee E15, and NA Employee E5). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on QAPI (Quality Assurance and Performance Improvement) for three of five employees (Nurse Aide (NA) Employee E15, and NA Employee E5, and Licensed Practical Nurse (LPN) Employee E16). Findings include: Review of the Facility assessment dated Quarter one 2025, indicated staff training/education and competencies will be completed during general orientation upon hire, annually, and as needed. Educations listed included:-Communication, resident rights and facility responsibilities, abuse, neglect and exploitation of residents, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health. Findings include: Review of facility provided documents and training records for NA Employees E15 and NA Employee E5 and LPN Employee E16, failed to include education on QAPI as required. Telephonic interview on 9/25/25, at 9:52 a.m. Human Resource Employee E9 confirmed that the facility failed to provide training on QAPI for three of five staff members (Nurse Aide (NA) Employee E15, and NA Employee E5, and Licensed Practical Nurse (LPN) Employee E16). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.</p>		