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	12/19/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident group meeting, clinical record review, observation and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R149).Findings include: Review of the clinical record indicated that Resident R149 was admitted to the facility on [DATE], with diagnoses which included hepatic encephalopathy (brain dysfunction caused by liver dysfunction), diabetes mellitus and morbid obesity. During an observation on 12/16/25, at 9:29 a.m. Resident R149's call light above her door illuminated, the call light was not responded to until 9:45 a.m., 16 mintute later, when Nurse Aide Employee E18 and Nurse Aide Employee E19. Review of facility provided documents Call Bell Audit's dated 12/11/15, 12/12/25, 12/16/25, revealed 12/11/25 room [ROOM NUMBER]: 21-minute response time, 12/12/25 room [ROOM NUMBER]: 20-minute response time, 12/16/25 room [ROOM NUMBER]: 16-minute response time. During an interview on 12/16/25, at 1:00 p.m. Registered Nurse Employee R12 confirmed that the facility failed to accommodate Resident R149's call bell needs. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code: 211.10(d) Resident care policies28 Pa. Code: 211.12(d)(1)(5) Nursing services

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility documents, resident clinical records, and staff interviews it was determined that the facility failed to maintain an environment free of abuse for one of five sampled residents (Resident R167).Findings include:The facility Abuse, neglect, exploitation prevention program policy dated 11/1/25, indicated residents have the right to be free from abuse, neglect, exploitation.Review of Resident R167's admission record indicated she was admitted on [DATE] and readmitted on [DATE]. Review of Resident R167's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/26/25, indicated she had diagnoses that included dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and hyperlipidemia (elevated lipid levels within the blood).Review of Resident R167's care plan dated 11/19/25, indicated if conflict arises to place Resident R167 in a calm and safe environment and allow her to vent.Review of Resident R167's clinical nurse note dated 11/19/25, indicated that at around 12:30 p.m. the Assistant Director of Nursing (ADON) Employee E4 entered resident's room and found Certified Nurse aide (CNA) Employee E6 and Licensed Practical Nurse (LPN) Employee E5 assisting resident into her wheelchair with a sit-to-stand lift. Assistant Director of Nursing (ADON) Employee E4 heard Licensed Practical Nurse (LPN) Employee E5 yelling at Resident R167 to stop it, you aren't a child. Stop acting like it. It appeared as if the Licensed Practical Nurse (LPN) Employee E5 pushed Resident R167 into the chair with the sling still around her waist. Facility investigation documents dated 11/19/25, Certified Nurse aide (CNA) Employee E6 witness statement was provided and indicated that Licensed Practical Nurse (LPN) Employee E5 yelled at Resident R167. Review of Licensed Practical Nurse (LPN) Employee E5 personnel record indicated she was hired 4/5/94. Her personnel record also indicated she received annual re-education for psychosocial needs dated 11/13/24 and annual re-education on abuse dated 4/27/25.During an interview on 12/16/25, at 8:54 a.m. Assistant Director of Nursing (ADON) Employee E4 was asked about incident with Licensed Practical Nurse (LPN) Employee E5: while Resident R167 was still hooked up to Hoyer lift pad, Licensed Practical Nurse (LPN) Employee E5 appeared to have pushed her down into a chair while she was hooked to a sit-to-stand machine and the sling was still around the resident. Licensed Practical Nurse (LPN) Employee E5 yelled in Resident R167's face to ‘stop acting like a child'.During an interview on 12/17/25, at 3:00 p.m. information disseminated to the Director of Nursing (DON) and Nursing Home Administrator (NHA) that the facility failed to maintain an environment free of abuse for Resident R167 as required. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights28 Pa. Code 211.12(d)(1)(3) Nursing services.