

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 12/30/2025
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain resident's confidential personal and medical records for one of three residents (Resident R1). Findings include: A review of the facility policy titled, Confidentiality of Information and Personal Privacy dated 1/18/25, indicated that the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Review of the clinical 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 11/21/25, indicated diagnoses of stroke (when blood stops flowing to a part of the brain), high blood pressure, and difficulty swallowing. During an observation on 12/30/25, at 12:07 p.m. a sign was observed posted above Resident R1's bed that included the following information: Blue [NAME] cup (a cup designed to limit the flow of liquids for residents who have difficulty swallowing) used for thin water. Only 5-10 ccs (milliliters) of liquid for each sip to reduce risk of aspiration (accidentally inhaling liquid into the lungs). Encourage resident to sit up when drinking. Review of Resident R1's clinical record failed to include any documentation that the above resident or his representative approved the posting of private health information. During an interview on 12/30/25, at 2:13 p.m. the Assistant Director of Nursing Employee E1 confirmed that the facility failed to maintain resident's confidential personal and medical records for one of three residents (Resident R1). 28 Pa. Code: 201.18(e)(1) Management		

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview it was determined that the facility failed to revise a care plan to accurately reflect the current status for one of three residents (Resident R1). Findings include: Review of facility policy Care Plans, Comprehensive Person-Centered dated 11/1/25, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Review of a Resident Representative concern dated 12/22/25, stated They are still giving him thin water through a straw. Review of the clinical 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 11/21/25, indicated diagnoses of stroke (when blood stops flowing to a part of the brain), high blood pressure, and difficulty swallowing. Review of Resident R1's clinical record revealed a physician's order dated 11/12/25, that stated No straws. A Review of Resident R1's care plan conducted on 12/30/25, did not include an intervention of No straws. During an interview on 12/30/25, at 1:43 p.m. the Assistant Director of Nursing confirmed the facility failed to revise care plan for Resident R1 as required. 28 Pa. Code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and resident and staff interviews it was determined that the facility failed to make certain that nail care was provided for four of ten residents (Resident R3, R4, R5, and R6). Findings include: Review of the facility policy Fingernails/Toenails, Care of last reviewed on 11/1/ 25, indicated that nail care includes daily cleaning and regular trimming. Review of a Resident Representative concern dated 12/22/25, stated the following: They don't clean or cut his nails. I'm the one that cuts his nails. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/23/25, indicated diagnoses of stroke (when blood stops flowing to a part of the brain), high blood pressure, and hemiplegia (paralysis on one side of the body). During an observation and interview on 12/20/25, at 11:16 a.m. Resident R3 was noted to have long fingernails, with brown debris underneath. State Agency (SA) asked Resident R3 if he needed his nails cut to which he replied Yeah. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, difficulty swallowing, and malnutrition (lack of nutrients in the body). During an observation on 12/30/25, at 11:12 a.m. Resident R4 was noted to have long fingernails. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of muscle weakness, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and low back pain. During an observation and interview on 12/30/25, at 11:30 a.m. Resident R5 was noted to have long and jagged fingernails. SA asked Resident R5 if she needed her nails cut, to which she replied, I need them cut but I don't know who cuts them. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), high blood pressure, and hip fracture. During an observation and interview on 12/30/25, at 11:31 a.m. Resident R6 was noted to have long fingernails with brown debris underneath. SA asked Resident R6 if he needed his nails cut and resident replied Yes, I do. During walking rounds with the Assistant Director of Nursing (ADON) Employee E1 on 12/30/25, from 12:29 p.m. to 12:36 p.m., the above observations were confirmed by ADON. During an interview on 12/30/25, at 12:36 p.m. the ADON confirmed that the facility failed to make certain that nail care was provided for four of ten residents. 28 Pa. Code:201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(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 - Some</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>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, resident interview, and staff interview, 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 three of three residents (Residents R1, R2, and R3). Findings include: Review of facility policy Prosthetic/Orthotic Management dated 11/1/25, indicated that splints are used to: Prevent and/or reduce contractures and deformity by applying prolonged, steady stretch of tight muscles/joint structures. Maintain proper joint positioning and alignment. Reduce pain and/or increase functional use of extremity by applying support for involved joint(s). Review of the clinical 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 11/21/25, indicated diagnoses of stroke (when blood stops flowing to a part of the brain), high blood pressure, and hemiplegia (paralysis on one side of the body). Review of Resident R1's clinical record revealed the following physician orders: Ankle brace with shoe during waking hours every day and evening shift. May remove when sleeping dated 4/12/25. Left palm guard on at bedtime remove in the morning dated 10/7/25. Left elbow splint on during the day and off at bedtime, dated 10/15/25. Left hand brace on in morning off at bedtime dated 10/15/25. Review of Resident R1's clinical record conducted on 12/30/25, revealed a Documentation Survey Report that revealed the following: Ankle Brace documentation was marked 'N for No, implying that brace was not applied on 12/2/25, 12/4/25, 12/22/25, 12/23/25, and 12/29/25. Ankle Brace documentation was marked NA for Not applicable on 12/3/25, 12/12/25, 12/13/25, 12/17/25, and 12/21/25. Ankle Brace documentation was left blank, with no supporting documentation that brace was applied on 12/7/25, 12/11/25, 12/14/25, and 12/16/25. Review of the above documentation indicated that Resident R1 did not have his ankle brace applied on 14 of 29 days. Left palm guard documentation was marked 'N for No, implying that guard was not applied on 12/4/25. Left palm guard documentation was marked NA for Not applicable on 12/14/25, 12/16/25, 12/18/25, and 12/24/25. Left palm guard documentation was left blank, with no supporting documentation that guard was applied on 12/11/25. Review of the above documentation indicated that Resident R1 did not have his palm guard applied on 6 of 29 days. Elbow splint documentation as marked NA for Not applicable on 12/3/25, 12/5/25, 12/6/25, 12/13/25, 12/15/25, 12/17/25, 12/21/25, and 12/29/25. Elbow splint documentation was left blank, with no supporting documentation that splint was applied on 12/7/25, 12/11/25, 12/14/25, 12/16/25, 12/24/25, and 12/25/25. Review of the above documentation indicated that Resident R1 did not have his elbow splint applied on 14 of 29 days. Hand brace documentation was marked 'N for No, implying that brace was not applied on 12/5/25, 12/18/25, 12/22/25, and 12/23/25. Hand brace documentation as marked NA for Not applicable on 12/6/25, 12/13/25, 12/15/25, 12/17/25, 12/21/25, and 12/29/25. Hand brace documentation was left blank, with no supporting documentation that brace was applied on 12/7/25, 12/11/25, 12/14/25, 12/16/25, 12/18/25, 12/24/25, and 12/24/25. Review of the above documentation indicated that Resident R1 did not have his hand brace applied on 15 of 29 days. Review of clinical record indicated Resident R2 was admitted to the facility 4/30/21. Review of Resident 2's MDS dated [DATE], indicated diagnoses of stroke, high blood pressure, and hemiplegia. Review of Resident R2's clinical record revealed a physician's order dated 11/20/25, for a Left-hand splint on at bedtime and off in the morning. During an interview on 12/30/25, at 11:10 a.m. Resident R2 confirmed that he was to wear a hand splint and stated, I don't even know where it's at anymore. Review of Resident R2's clinical record conducted on 12/30/25, revealed a Documentation Survey Report that revealed the following: Hand splint documentation was marked 'N for No, implying that brace was not applied on 12/3/25, 12/8/25, 12/22/25, and 12/23/25. Hand splint documentation as marked NA for Not applicable on 12/6/25, 12/27/25, and 12/28/25. Hand splint documentation was left blank, with no supporting documentation that brace was applied on 12/4/25, 12/12/25, 12/13/25, 12/15/25, 12/17/25, 12/18/25, 12/20/25, 12/21/25, 12/24/25, 12/25/25, and 12/29/25. Review of the above documentation indicated that Resident R2 did not have his hand splint applied on 18 of 29 days. Review of clinical record indicated Resident R3 was admitted to the facility 2/13/25. Review of Resident 3's MDS dated [DATE], indicated diagnoses of stroke, high blood pressure, and hemiplegia. Review of Resident R3's clinical record revealed a physician's order dated 10/15/25, for a splint to right hand, apply at bedtime and remove in the morning. Review of Resident 32's clinical record conducted on 12/30/25, revealed a Documentation Survey Report that revealed the following: Hand splint documentation as marked NA for Not applicable on 12/2/25</p>		