| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395826 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Highland Hills Post Acute | 1105 Perry Highway<br>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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**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 make certain that the necessary resident information was communicated to the receiving health care provider for two of four residents (discharged Resident R1 and Resident R3).Findings include: Review of facility policy Transfer and discharge process last reviewed 11/1/25, indicated residents, or their representatives are provided with written notification of an impending transfer or discharge. Information conveyed to a receiving provider includes but is not inclusive of:Practitioners contact informationResident representative informationAdvanced directivesAll special instructions or precautions for ongoing careComprehensive care plan goalsAll other necessary information, including a copy of the resident's discharge summary The medical record must contain the discharge summary information and recipient of the summary. Review of the clinical record indicated discharged Resident R1 was admitted to the facility on [DATE]. Review of discharged Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated the diagnosis of high blood pressure, anxiety and chronic respiratory failure. Review of the clinical record indicated discharged Resident R1 was transferred to the hospital on 3/8/26 and did not return to the facility. Review of discharged Resident R1's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. 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 2/14/26, indicated the diagnosis of high blood pressure, diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood). Review of Resident R3's nursing progress notes dated 3/5/26, indicated resident became unresponsive during lunch in wheelchair vital signs blood /pressure (B/P) 88/50, (healthy adult normal between 120/60) heart rate 75 (healthy adult normal 60-100), oxygen saturation 95% (healthy adult normal 95-100%) respirations 26 (health adult normal 18-20), maximum assistance of four staff to return to bed. Resident became more aroused B/P 110/58, heart rate 71, respirations 21, pulse ox 94%. Able to appropriately answer questions. Per nurse practitioner send to hospital for evaluation, niece in agreement to go to hospital. Review of Resident R3's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview completed on 3/19/26, at 1:05 p.m. the Assistant Director of Nursing (ADON) Employee E1 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of four residents (discharged Resident R1 and Resident R3). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights |

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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| Highland Hills Post Acute | 1105 Perry Highway<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined and failed to obtain failed to obtain a physician order for a hospital transfer for one of four residents (Resident R3) and failed to obtain physician orders for management of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for one of two residents (discharged Resident R2).Findings include: 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 2/14/26, indicated the diagnosis of high blood pressure, diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood). Review of Resident R3's nursing progress notes dated 3/5/26, indicated resident became unresponsive flaccid during lunch in wheelchair vital signs blood /pressure (B/P) 88/50, (healthy adult normal between 120/60) heart rate 75 (healthy adult normal 60-100), oxygen saturation 95% (healthy adult normal 95-100%) respirations 26 (health adult normal 18-20), maximum assistance of four staff to return to bed. Resident became more aroused B/P 110/58, heart rate 71, respirations 21, pulse ox 94%. Able to appropriately answer questions. Per nurse practitioner send to hospital for evaluation, niece in agreement to go to hospital. Review of Resident R3's physician orders failed to include an order to transfer to the hospital. During an interview completed on 3/19/26, at 1:05 p.m. the Assistant Director of Nursing (ADON) Employee E1 confirmed that the facility failed to obtain a physician order for a hospital transfer for one of four residents (Resident R3) Review of the clinical record indicated discharged Resident R2 was admitted to the facility on [DATE]. Review of discharged Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/14/26, indicated the diagnosis of anemia (low iron in the blood) diabetes (high sugar in the blood) and high blood pressure. Review of discharged Resident R2's physician orders dated 1/28/26, indicated Humalog Solution 100 unit/milliliter (ML) (Insulin Lispro (fast acting insulin) Inject as per sliding scale (matches the current blood sugar reading (measurement of glucose (sugar) in the blood) to a corresponding insulin dose:if 0 - 150 = 0 units151 - 200 = 2 units201 - 250 = 4 units251 - 300 = 6 units301 - 350 = 8 units351 - 400 = 10 unitssubcutaneously before meals and at bedtime for diabetes. The physician order failed to contain parameters for when to contact the physician regarding hypoglycemia or hyperglycemia capillary blood glucose checks. During an interview completed on 3/19/26, at 1:18 p.m. Assistant Director of Nursing (ADON) Employee E1 confirmed that the facility failed to obtain physician orders for management of hypoglycemia and hyperglycemia for one of two residents (discharged Resident R2). 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(5) Nursing services. |