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	06/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to obtain a physician order for wound care and failed to provide appropriate treatment and care in accordance with professional standards of practice for one of four residents (Resident R1).Findings include: Review of facility policy Negative Pressure Wound Therapy (NPWT) dated 11/1/25, indicated NPWT requires cleansing and debridement of the wound, protection of the surrounding skin, and an airtight seal. Stop the pump and remove the dressing if the device stops working for more than 2 hours. Apply saline-moistened dressing and notify the provider. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of infection and inflammatory reaction due to internal left knee prosthesis, high blood pressure, and presence of left artificial knee joint. Review of Resident R1's hospital discharge orders dated 6/10/26, indicated wound to left knee, clean with Vashe (a wound cleanser used to prevent and treat infections), pat dry, Adaptic film (a clear, non-adherent dressing used to protect the wound bed) applied, 125 mmHg (Millimeters of mercury) wound VAC (vacuum-assisted wound closure, NPWT). Wound VAC change MWF (Monday, Wednesday, Friday) or PRN (as needed). Review of Resident R1's Admission/readmission Evaluation/assessment dated [DATE], indicated the resident had a left knee surgical incision and stated, wet to dry dressing until wound vac arrives. Review of a skin and wound progress note dated 6/11/26, stated, Hospital course notable for recurrent left knee prosthetic joint infection with wound dehiscence (unintended separation or opening of a wound or surgical incision) and wound VAC placement. Patient was transferred to facility on 6/10/26 with plan to continue wound VAC and continue IV (intravenous) cefazolin (an antibiotic) through 6/29/26. Left knee open surgical treatment recommendations: cleanse with wound cleanser, apply wound VAC @ 125 mmHg continuous therapy, per Surgeons request to base of the wound, secure with transparent film, change 3 times per week, every M/W/F. Review of a physician order dated 6/12/26, indicated left knee wound: cleanse with Vashe, pat dry, apply Adaptic film and wound vac @ 125 mmHg every day shift every Monday, Wednesday, Friday and PRN for displacement. Review of nursing documentation dated 6/12/26, indicated the above order was not completed as ordered, stating, wound vac not present yet. Review of a resident representative concern dated 6/14/26, stated, My loved one was admitted on the evening of June 10th 2026 with the expectation of a wound vac being available. Upon my visit on Thursday the 11th there was still no wound vac. I called on Friday the 12th to check the status of the equipment. I was told they were still waiting for the equipment to be delivered but a wet to dry dressing had been applied the day before, which I did see while visiting the night before. The dressing was dated 6/11. While visiting today I saw that she still does not have a wound vac and her dressing still had the same date from 6/11 on it. I notified staff who told me there was never an order placed to change the dressing. Review of a skin and wound progress note dated 6/15/26, stated, Left knee is ordered a wound vac @ 125 mmHg continuous therapy - current treatment is dakins (a wound healing solution) moistened gauze due to wound vac supplies not arriving to facility yet, due to arrive today with plans to apply wound vac as soon as the supplies are available. Review of a physician order dated 6/15/26, indicated to apply a wet to dry dressing to L (left) knee, change daily, may DC (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(discontinue) when wound vac is placed every day shift for wound care. This order was documented as completed on 6/15/26. Review of Resident R1's physician orders failed to include additional wound dressing orders for 6/10/26, through 6/14/26. Review of Resident R1's clinical record failed to include documentation that the left knee dressing was changed On 6/11/26, 6/12/26, 6/13/26, and 6/14/26. During an interview on 6/16/26, Resident R1 stated, I think they were having problems getting the wound vac. They put it on yesterday but I think I broke the tubing last night when I took myself to the bathroom. They took it off and put a dressing on my knee today. I can't remember if anyone from the facility changed the dressing from when I was admitted to yesterday when I had the wound vac placed. During an interview on 6/16/26, at 12:40 p.m. the Director of Nursing confirmed the facility failed to obtain a physician order for wound care and failed to provide appropriate treatment and care in accordance with professional standards of practice for Resident R1. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers (PU/PIs - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of four residents (Resident R2).Findings include: Review of facility policy Prevention of Pressure Injuries dated 11/1/25, indicated the purpose of this procedure is provide an overview of current standards of practice for pressure injury prevention. Interventions are individualized according to each resident's risk factors for pressure injury, clinical condition, and resident wishes for goals and care. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. For example, reposition every 2-3 hours when an appropriate pressure redistribution support surface is used. Review of facility policy Charting and Documentation dated 11/1/25, indicated all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/10/26, indicated diagnoses of high blood pressure, hemiplegia (paralysis or severe weakness affecting one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain) affecting right dominant side, and need for assistance with personal care. Section GG0170A indicated the resident was coded 2 substantial/maximal assistance for the ability to roll from lying on back to left and right side, returning to lying on back on bed. Review of a resident representative concern dated 6/15/26, stated, There is no regular movement or repositioning. Review of Resident R1's comprehensive care plan dated 5/20/26, indicated the resident is at risk for skin breakdown related to activity intolerance, cognitive impairment, and impaired mobility. Interventions include assist to turn and reposition as indicated/tolerated. Review of Resident R1's June 2026 turn and reposition documentation indicated the task was not completed on the following shifts:6/1/26 11 p.m. - 7 a.m. shift, documentation blank6/2/26: 3 p.m. 11 p.m. shift and 11 p.m. - 7 a.m. shift were documented NA not applicable, with no further documentation available to explain why turn and repositioning was not applicable.6/3/26 3 p.m. 11 p.m. shift and 11 p.m. - 7 a.m. shift were documented NA not applicable, with no further documentation available to explain why turn and repositioning was not applicable.6/7/26 3 p.m. 11 p.m. shift and 11 p.m. - 7 a.m. shift were documented NA not applicable, with no further documentation available to explain why turn and repositioning was not applicable.6/9/26 3 p.m. - 11 p.m. shift, documentation blank6/11/26 7 a.m. - 3 p.m. shift, documentation blank6/13/26 7 a.m. - 3 p.m. shift was documented NA not applicable, with no further documentation available to explain why turn and repositioning was not applicable.6/15/26 3 p.m. - 11 p.m. shift, documentation blank During an interview on 6/16/26, at 9:46 a.m. Resident R2 stated, I don't get turned and repositioned, some staff offer to do it, some don't. It's not consistent. During an interview on 6/16/26, at 1:13 p.m. the Director of Nursing confirmed that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers for Resident R2. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10 (c)(d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.