

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for the facility's Automated External Defibrillators (AED-a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias) (Second floor and first floor) and crash cart (a supply cart used in an emergency - second floor). Findings include:Review of the facility provided Heart Start FRx 86/304 AED's Owner Manual' dated Edition 8, indicated the AED's extensive automatic self-test features eliminates the need for any manual calibrations. Other than checks recommended after each use, replace any used, damaged or expired supplies and accessories.Observation of the facility's AED box on the second floor, [DATE], at 9:41 a.m. revealed an AED with AED Smart Pads II attached to the machine with an expiration date of [DATE].Observation of the second-floor crash cart on [DATE], at 9:41 a.m. revealed the crash cart checklist log failed to be completed from [DATE], -[DATE].Interview on [DATE], at 9:45 a.m. Registered Nurse (RN) Manager Employee E8 confirmed the crash cart checklist log was not completed on [DATE] -[DATE], and that AED Smart Pads II were expired.Observation of the facility's AED box on the first floor on [DATE], at 10:16 a.m. revealed an AED with AED Smart Pads II attached to the machine with an expiration date of [DATE].Interview on [DATE], at 10:17 a.m. RN Employee E12 confirmed that AED Smart Pads II were expired.Interview on [DATE], at 3:00 p.m. the Director of Nursing confirmed the facility failed to make certain that equipment was in safe operating condition for the facility's Automated External Defibrillators (Second floor and first floor) and crash cart (second floor).28 Pa Code: 201.14(a) Responsibility of licensee.		

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 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to follow established procedures of water storage to ensure that water is available to essential areas when there is a loss of normal water supply. Findings include: Review of the facility policy Emergency Preparedness and Planning dated 11/1/25, indicated the emergency water supply overall total water amount recommended by the Red Cross and FEMA is one gallon per person per day. Further review of the Emergency Water Supply plan indicated total bed capacity is 200 residents, with a total staff of 105 to equal 305 total people. The total people 305 times one gallon, times three days equals 915 gallons. Tour of the facility, with Maintenance Director Employee E25 on 12/17/25, at 11:08 a.m. revealed the Long-Term Care Supply Room that stored one-gallon containers of water in the form of six gallons/box with 16 boxes to equal a total of 96 gallons. The estimated volume for this storage area is 100 gallons. Interview with Maintenance Director Employee E25 on 12/17/25, at 11:10 a.m. confirmed the facility did not meet the adequate volume for that storage area as per their plan. Tour of the facility, with Maintenance Director Employee E25 on 12/17/25, at 11:20 a.m. revealed the Arcadia storage area stored 36 one-gallon jugs on top shelves, with five gallon jugs on the lower shelves. Total volume available equaled 161 gallons. The estimated volume for this storage area is 200 gallons. Interview with Maintenance Director Employee E25 on 12/17/25, at 11:23 a.m. confirmed the facility did not meet the adequate volume for that storage area as per their plan and indicated that the facility has emergency water available in the boiler room's water heaters of 100 gallons, 214 gallons in toilet tanks (134 toilets times 1.6 gallons equals 214.4 gallons), and storage tanks in the boiler room equal to 390 gallons. During further, questioning of Maintenance Director Employee E25 on 12/17/25, at 11:25 a.m. it was pointed out that the total amount of drinking water was inadequate with only 257 gallons stored in gallon jugs, when at total of 915 gallons was required for the facility data, and that the water in the water heaters, storage tanks in boiler room and water in toilet tanks was not acceptable for drinking water. During an interview on 12/17/25, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to have required amounts of drinkable emergency water supply on hand at this time for residents and staff in case of an emergency. 28 Pa. Code 201.18(b)(1) Management		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations and staff interview, it was determined that the facility failed to determine whether it was safe to self-administer medications for four of seven residents (Resident R31, R40, R70 and R102). Findings include: Review of the facility policy Self-Administration of Medications dated 11/1/25, indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Review of Resident R31's clinical record indicated an admission date of 2/11/21. Review of R31 's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/15/25, indicated diagnosis of anemia (low iron in the blood), heart failure (heart doesn't pump the way it should), and chronic obstructive pulmonary disease (COPD- causes breathing problems). Observation 12/16/25 at 9:15 a.m. indicated a bottle of nasal spray sitting on Resident R31's bedside stand. Review of Resident R31's physician orders failed to include an order for self-administration of medications. Review of Resident R31's care plan failed to include interventions for medication self-administration. Interview 12/16/25, at 9:18 a.m. Registered Nurse Employee E10 removed the nasal spray from the room and confirmed the absence of a physician order or care plan to self-administer medications. Review of Resident R102's clinical record indicated an admission date of 11/22/23. Review of R102's MDS dated [DATE], indicated diagnosis of chronic obstructive pulmonary disease (COPD- causes breathing problems), anemia (low iron in the blood) and depression. Observation 12/15/25, at 11:00 a.m. of Resident R102's bedside table revealed a medicine cup with red liquid. Upon asking Resident R102 what is in the cup replied, it's my cough medicine it's in here from last night so I can take it when I want. Review of Resident R102's physician orders failed to include an order for self-administration of medications. Review of Resident 102's care plan failed to include interventions for medication self-administration. Interview 12/15/25, at 11:08 a.m. RN Employee E10 removed the medicine cup from the room and confirmed the absence of a physician order or care plan to self-administer medications. Review of the admission record indicated Resident R70 was admitted to the facility on [DATE]. Review of Resident R70's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/30/25, indicated the diagnoses of chronic kidney disease, adult failure to thrive and anemia. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/15/25, at 10:30 a.m. of Resident R70's room indicated a one medicine cup with 4 pills. Review of Resident R70's physician orders dated 12/11/25 indicated Calcium Carbonate-Vit D-Min Oral Tablet 600-400 MG-UNIT give 1 tablet by mouth one time a day for hypocalcemia, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG give one tablet by mouth one time a day for HTN, Nifedical XL Oral Tablet Extended Release 24 Hour 60 MG give one tablet by mouth one time a day for HTN, Apixaban Oral Tablet 5 MG give five mg by mouth two times a day for DVT treatment/prevention. Interview with Registered Nurse (RN) Employee E12 confirmed the cup with four tablets were at the bedside unattended. Review of Resident R70's clinical record failed to have a physician order, assessment, or plan of care addressing self-administration of medications. Review of the admission record indicated Resident R40 was admitted to the facility on [DATE]. Review of Resident R40's MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), morbid obesity, and muscle wasting and atrophy. Observation on 12/15/25, at 11:30 a.m. of Resident R40's room indicated one medicine cup and an inhaler at the bedside table. The medicine cup had four Tums. Review of Resident R40's physician orders dated 12/14/25 indicated Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT one puff inhale orally four times a day for COPD and Tums Oral Tablet Chewable 500MG (Calcium Carbonate (Antacid) give one tablet by mouth every eight hours as needed for dyspepsia. Interview with Registered Nurse (RN) Employee E12 confirmed the cup with four tablets were tums and the inhaler at the bedside unattended. Review of Resident R40's clinical record failed to have a physician order, assessment, or plan of care addressing self-administration of medications. Interview on 12/15/25, at 12:00 p.m. RN Employee E12 confirmed the medications were stored in the resident room inappropriately and that Resident R40, R70 failed to have an assessment, physician order, or plan of care for self-administration of medications. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, resident clinical records, and staff interviews it was determined that the facility failed to include hypoglycemia protocols for one of three sampled residents (Resident R19) and failed to obtain a physician order for three of four residents (Resident R10, R102 and R149). Findings include: Review of the facility policy Medication and Treatment Orders last reviewed 11/1/25, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications. Review of Resident R10's clinical record indicated an admission date of 7/8/23. Review of R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/25, indicated the diagnosis of hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (COPD- restricts breathing), and hyperlipidemia (high fats in the blood). Observation on 12/15/25, at 9:37 a.m. of Resident R10's room indicated a handheld nebulizer (used to deliver respiratory medicine) on the nightstand. Review of Resident R10's physician orders on 12/19/25, failed to include medication for use in the handheld nebulizer. Interview completed on 12/19/25, at 8:54 a.m. Registered Nurse (RN) Employee E10 confirmed that there were not any current orders for the medication for the handheld nebulizer and stated, I found one that was discontinued on 12/2/25. Review of Resident R102's clinical record indicated an admission date of 11/22/23. Review of R102's MDS dated [DATE], indicated diagnosis of chronic obstructive pulmonary disease (COPD- causes breathing problems), anemia (low iron in the blood) and depression. Observation 12/15/25, at 11:00 a.m. of Resident R102's bedside table revealed a medicine cup with red liquid. Upon asking Resident R102 what is in the cup replied, it's my cough medicine it's in here from last night so I can take it when I want. Review of Resident R102's physician orders on 12/19/25, failed to include orders for cough medicine. Review of clinical record indicated Resident R149 was admitted to the facility on [DATE], with diagnoses of diabetes mellitus, morbid obesity and hepatic encephalopathy (brain dysfunction caused by liver dysfunction). Review of Resident R149's MDS dated [DATE], revealed the diagnoses were current. During an observation on 12/16/25 at 10:30 a.m. Resident R149 asked surveyor to check her offloading boot for her right heel in her bed. Review of Resident R149's physician orders dated 12/5/25 indicated no active physician order for an offloading boot. During an interview on 12/18/25, at 2:00 p.m. Assistant Director of Nursing Employee E4 confirmed Resident R149 did not have an active order for an offloading boot as required. During an interview completed on 12/19/25, at 11:08 a.m. RN Employee E10 confirmed there were not any orders for the cough medicine and stated, It was discontinued on 11/24/25, I updated this order on Monday, I don't know why it's not in there. The facility Management of hypoglycemia policy reviewed March 2025, and last reviewed 11/1/25, indicated that hypoglycemia signs and symptoms may include dizziness, restlessness, excessive perspiration, headache, or numbness. For instances of blood glucose below 70, give resident oral form of rapid absorbed glucose, notify the provider and remain with the resident. Documentation instructions included to document provider instructions. The Centers for Disease Control define diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's (capillary blood glucose). Review of Resident R19's admission record indicated he was admitted on [DATE] and re-admitted on [DATE]. Review of Resident R19's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 7/21/25, indicated he had diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), and repeated falls. Review of Resident R19's care plans dated 7/16/25, indicated that Resident R19 has diabetes, he is at risk of hyperglycemia and hypoglycemia, and initiate appropriate protocols. Review of Resident R19's physician orders dated 7/15/25, indicated to provided three times per day with meals Insulin Lispro (a short acting, manmade version of human insulin) Pen-injector 100 UNIT/ML (milliliter) inject as per sliding scale: 70 - 140 = 0 units;141 - 180 = 1 units; 181 - 220 = 2 units; 221 - 260 = 3 units;261 - 300 = 4 units; 301 - 340 = 5 units; Greater than 340= give 6 units and call doctor. Review of Resident R19's physician orders and physician notations did not include a hypoglycemia protocol for Resident R19 in the event his blood glucose level is below 70. During an interview on 12/17/25, at 10:07 a.m. Agency Licensed Practical Nurse (LPN) Employee E2 was asked what actions to take if resident is hypoglycemic: give the resident something that has sugar or the gel that goes on their tongue. When asked about the Hypoglycemia instructions missing from the physician order, she stated: I believe the sliding scale should be in the order. During an interview on 12/17/25, at 10:20 a.m. Agency Licensed Practical Nurse (LPN) Employee E3 was asked if sliding scale should include Hypoglycemia protocol: The sliding scale should be in the physician order. It may be put in separately. During an interview on 12/17/25, at 12:53 p.m. the Director of Nursing (DON) confirmed that the facility failed to include hypoglycemia protocols in the physician orders for Resident R19 as required. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident rights 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for four of six residents (Residents R10, R127, R158 and R172). Findings include: Review of the facility policy Respiratory Equipment Change and Cleaning Guidelines last reviewed 11/1/25, indicated handheld nebulizers (used to deliver respiratory medicine) are to be labeled and dated with the room number/bed, they are stored in plastic bag when not in use. Nasal cannulas (thin tubing placed in nostrils to deliver supplemental oxygen) are to be labeled and dated when changed and stored in plastic bag when not in use. Continuous Positive Airway Pressure (CPAP-keeps airways open when you sleep) or Bilevel Positive Airway Pressure (BIPAP-normalizes breathing by delivering pressurized air) are to be labeled with room number/bed and to be stored in a plastic bag when not in use. Review of Resident R10's clinical record indicated an admission date of 7/8/23. Review of R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/25, indicated the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- restricts breathing), and hyperlipidemia (high fats in the blood). Observation on 12/15/25, at 9:37 a.m. of Resident R10's room indicated a handheld nebulizer on the nightstand, not dated or stored in a bag as required. Interview on 12/15/25, at 11:12 a.m. Registered Nurse (RN) Employee E10 confirmed the nebulizer on the stand was not dated or stored in a bag as required. Review of the clinical record indicated Resident R127 was admitted to the facility on [DATE]. Review of Resident R127's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked). Review of Resident R127's physician order dated 12/7/25, indicated CPAP setting 5 FiO2 (fraction of inspired oxygen) 30, and SpO2 (peripheral capillary oxygen saturation) of 97 percent every night shift for breathing. Review of Resident R127's current care plan failed to include management and use of the CPAP machine as ordered. Review of Resident R127's medication administration record dated December 2025 indicated the CPAP was administered from 12/7/25, through 12/10/25. Observation completed on 12/16/25, at 10:23 a.m. Resident R127 was in bed, with the CPAP machine at bedside. The mask was not stored in a bag as required. Interview on 12/16/25, at 10:23 a.m. Resident R127 indicated using the CPAP machine every night. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview completed on 12/16/25, at 10:23 a.m. Assistant Director of Nursing (ADON) Employee E4 confirmed Resident R127's CPAP mask was not in a bag as required and failed to be included in the care plan. Review of the clinical record indicated Resident R158 was admitted to the facility on [DATE]. Review of Resident R158's MDS dated [DATE], indicated diagnoses of aphasia (language disorder that affects speech and understanding of language), hemiplegia (paralysis on one side of the body) and cerebrovascular accident (CVA-stroke blood flow to brain becomes damaged due to lack of blood flow). Review Resident R158's physician order dated 3/5/25, indicated Auto CPAP at bedtime. Maximum inspiration positive airway pressure (IPAP) 15 centimeters of water column (cmH2O-measure of pressure) minimum expiratory positive airway pressure (EPAP) 5cmH2O pressure at bedtime for obstructive sleep apnea. Observation on 12/15/25, at 11:24 a.m. indicated a CPAP sitting on top of fall mat placed on the floor on the left side of the bed. Interview 12/15/25, at 11:28 a.m. RN Employee E10 confirmed the CPAP machine was sitting on top of the fall mat and was not dated or stored in as bag as required. Review of the clinical record indicated Resident R172 was admitted to the facility on [DATE]. Review of Resident R172's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure), hemiplegia (paralysis on one side of body) and anxiety. Review of Resident R172's physician order dated 12/11/25, indicated oxygen at 3 liters per minute (LPM) via nasal canula continuous. Observation on 12/15/25, at 10:53 a.m. Resident R172 was in her room, her oxygen was on via nasal canula, the tubing failed to be labeled with a date/time as required. Interview on 12/15/25, at 11:11 a.m. RN Employee E10 confirmed the oxygen tubing failed to be labeled with a date/time as required. During an interview completed on 12/15/25, at 3:00 p.m. the director of nursing confirmed that the facility failed to provide appropriate respiratory care for four of six residents (Residents R10, R127, R158 and R172). 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)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R7) and failed to ensure that Enhanced Barrier Precautions were managed properly for three of three residents (Resident R16, Resident R89, and Resident R159). Findings include: Review of the facility policy Dressings, Dry/Clean last reviewed 11/1/25, indicated wash and dry hands thoroughly. Put on clean gloves, remove soiled dressing discard into plastic or biohazard bag. Wash and dry your hands thoroughly. Review of the facility policy Enhanced Barrier Precautions dated 11/1/25, indicated Enhanced Barrier Precautions (EBP's) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. EBPs employ targeted gown and glove use during high contact resident care activities (for example dressing, bathing/showering, providing hygiene, changing briefs or assisting with toileting, etc.). Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. Review of Resident R7's clinical record indicated admission to facility on 8/20/24. Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/8/25, indicated diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood) and depression. Review of R7's physician orders dated 11/20/25, indicated Left Heel: cleanse with wound cleanser, apply Santyl ointment and calcium alginate to wound bed, cover with foam dressing. Observation of dressing change on 12/16/25, at 12:58 p.m. Registered Nurse (RN) Employee E12 removed Resident R7's soiled dressing, cleansed the wound and continued to apply the Santyl ointment, and calcium alginate. Licensed Practical Nurse (LPN) Employee E11 was assisting with dressing change by holding Resident R7's left heel off of bed. LPN Employee E11 placed Resident R7's heel down on a washcloth that was being used as a barrier, removed gloves completed hand hygiene and returned to treatment cart to retrieve a foam cover dressing. Upon returning to room LPN Employee E11 completed hand hygiene and donned new gloves, lifted Resident R7's leg up and RN Employee E12 placed the foam cover dressing. During an interview completed on 12/16/25 at 1:31 p.m. RN Employee E12 confirmed hand hygiene was not completed after removal of soiled dressing and cleansing wound. LPN Employee E11 confirmed placing Resident R7's heel down on the washcloth after the Santyl and calcium alginate were applied and lifting it back up to allow for placement of the cover dressing increasing the risk of cross contamination to wound. Review of the admission record indicated Resident R16 admitted to the facility on [DATE]. Review of Resident R16's MDS dated [DATE], indicated the diagnoses of high blood pressure, atrial fibrillation (irregular heart rhythm), and BPH (enlarged prostate gland that squeezes the urethra). Section H0100 indicated a foley catheter is in use. Review of Resident R16's care plan dated 11/3/25, indicated EBP, resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of an indwelling device. Observation on 12/16/25, at 1:08 p.m. Nurse Aide (NA) Employee E24 and two other unidentified NAs were assisting Resident R16 in the Grand Heritage resident bathroom across from the nurses' desk. Resident R16 had a foley catheter under the wheelchair as staff escorted resident out of the bathroom. No gowns were observed in the bathroom or on the staff. Interview on 12/16/25, at 1:10 p.m. NA Employee E24 indicated not being aware that an indwelling catheter needed EBP and to wear a gown during care and confirmed gowns were not utilized as required. Review of the admission record indicated Resident R89 admitted to the facility on [DATE], with the diagnoses of lung cancer, encephalopathy (broad term for diffuse brain disease that alters the function or structure), and cardiomegaly (enlarged heart). Observation on 12/15/25, at 9:20 a.m. Resident R89 was observed in bed with a foley catheter. The room failed to have a sign posted on the door or wall (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outside the resident's rooms which communicates the type of precautions and PPE (personal protective equipment) required. Review of the admission record indicated Resident R159 admitted to the facility on [DATE]. Review of Resident R159's MDS dated [DATE], indicated high blood pressure, heart failure (heart doesn't pump blood as well as it should), and BPH. Section H0100 indicated a foley catheter is in use. Observation on 12/15/25, at 9:40 a.m. Resident R159 was noted in the hallway in the wheelchair with a foley catheter under the chair. Observation of Resident R159's room failed to have a sign posted on the door or wall outside the resident's rooms which communicates the type of precautions and PPE required. Interview and tour with Registered Nurse (RN) Employee E9 confirmed Resident R159's doorway failed to include signage to communicate with staff the need for EBP. Interview on 12/19/25, at 12:45 p.m. the Director of Nursing confirmed the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R7) and failed to ensure that Enhanced Barrier Precautions were managed properly for three of three residents (Resident R16, Resident R89, and Resident R159). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.28 (b)(1)(e)(1) Management.28 Pa Code: 211.10 (d) Resident care policies.		

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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		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide a Skilled Nursing Advanced Beneficiary Notice of Non-coverage (SNF-ABN) for one of three sampled resident records (Resident R134). Findings include: The facility Medicare Advanced Beneficiary Non-coverage notices policy reviewed 11/1/2024, indicated a resident is informed in advance and in writing when Medicare payment denial or change in coverage is likely. Written notices are provided to the resident as soon as the facility makes the assessment that Medicare payment certainly or probably will not be made. Review of Resident R134's admission record indicated he was originally admitted on [DATE] and readmitted on [DATE]. Review of Resident R134's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 10/7/25, indicated he had medical diagnoses included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), aphasia (difficulty swallowing), hyperlipidemia (elevated lipid levels within the blood), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Facility documents indicated that Resident R134 had exhausted 100 days of Medicare and he was no longer Medicare eligible as of 10/28/25. Review of Resident R134's census documentation indicated he was a Medicaid Pending resident as of 10/29/25. Review of Resident R134's resident records, nurse notes, and social services notes did not show evidence of an Skilled Nursing Facility- Advanced Beneficiary Notice (SNF-ABN) being provided to Resident R134. During an interview on 12/16/25, at 9:57 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that the facility failed to provide a SNF-ABN to Resident R134 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2)(3) Management		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of facility policy, resident council group interview, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three common areas (Vending machine area). Findings include: The facility Homelike environment policy last reviewed on 11/1/25, indicated to provide a safe, clean and comfortable environment. Comfortable and safe temperatures include between 71° and 81°. During a Resident council group interview on 12/16/25, at 1:46 p.m. three out of eight residents voiced concerns that the Grand Heritage room with the vending machines was cold. During an interview on 12/17/25, at 9:35 a.m. Maintenance Supervisor Employee E25 stated: some of the heating units need replaced. It's been like this for a couple of months. During a tour of facility rooms and common areas on 12/17/25, at 9:36 a.m. observations of the vending machine rooms on Grand heritage found the room temperature to be 55°. During an interview on 12/17/25, at 2:45 p.m. information disseminated to the Director of Nursing (DON) and Nursing Home Administrator (NHA) that the facility failed to maintain temperatures and a comfortable environment in one resident common area. 28 Pa. code: 201.14 (b) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.		

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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 Rights. 28 Pa. Code 211.12(d)(1)(3) Nursing services.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 conduct a thorough investigation of an injury obtained during care to eliminate possible neglect for one of five residents (Resident R11). Findings include: Review of facility Abuse, Neglect, Exploitation and Misappropriation Prevention Program last reviewed 11/1/25, indicated the program consists of a facility wide commitment and resource allocation to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident's property. Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE]. Review Resident R11's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/20/25, indicated diagnoses of anemia (low iron in the blood), heart failure (heart doesn't pump the way it should) and seizure disorder (surge of abnormal electrical activity in the brain causing loss of consciousness and uncontrollable movements). Observation 12/15/25, at 9:30 a.m. Resident R11 was sitting in her chair, a thin scab was noted to her left side of forehead above eyebrow. Review of Resident R11's plan of care for Falls indicated resident is at risk for falls with or without injury related to altered balance while standing and/or walking. Review of Resident R11's progress note dated 12/13/25, at 10:04 p.m. indicated Late Entry: Per Nurse Aid (NA) statement, she was cleaning her up on her bed and went to the restroom, as NA came back after a few seconds the resident was laying on the floor on the right side of her bed. Registered Nurse (RN) was called, as I went to the room, the resident was lying on her left side beside her bed. The resident was assessed, a small, tiny skin tear noted on her left eyebrow with light signs of blood which is stopped already. Vitals were taken helped the resident to get in bed. The supervisor was notified; a phone call was placed to the family and voice message left for the resident's PCP office. Review of nursing progress note dated 12/15/25, at 2:15 p.m. IDT (interdisciplinary team) reviewed fall from 12/13/25, intervention: staff to provide all care prior to leaving room. Review of an employee statement dated 12/13/25, written at 10:10 p.m. by NA Employee E20 indicated went to bathroom to get water to wash resident came back and she was on the floor. Review of an employee statement dated 12/13/25, written at 10:10 p.m. by NA Employee E21 stated, I was in the resident's room across the hall when I heard her say the resident fell. When I went over, she was on the floor. I went to get the nurse while aid stayed with resident. Further review of facility provided investigation on 12/18/25, failed to include signed and dated witness statements from all staff members who had contact with the resident during the shift incident occurred. During an interview on 12/19/25, at 9:00 a.m. the Director of Nursing confirmed that the facility failed to conduct a thorough investigation of an injury obtained during care to eliminate possible neglect for one of five residents (Resident R11). 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.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) accurately reflected the resident's status for two of four residents (Resident R127 and R161). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of care needs), dated October 2025, indicated the following instructions: Intent: The intent of the items in this section (Section O) is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods. O0110: Special Treatments, Procedures, and Programs. Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures. Review of the clinical record indicated Resident R127 was admitted to the facility on [DATE]. Review of Resident R127's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked). Section O0110 G3 CPAP (non-invasive treatment for sleep apnea that uses a machine to deliver pressurized air through a mask, keeping the airway open during sleep to prevent breathing pauses) was not indicated as in use. Review of Resident R127's physician order dated 12/7/25, indicated CPAP setting 5 FiO2 (fraction of inspired oxygen) 30, and SpO2 (peripheral capillary oxygen saturation) of 97 percent every night shift for breathing. Review of Resident R127's current care plan failed to include management and use of the CPAP machine as ordered. Review of Resident R127's medication administration record dated December 2025 indicated the CPAP was administered from 12/7/25, through 12/10/25. Observation completed on 12/16/25, at 10:23 a.m. Resident R127 was in bed, with the CPAP machine at bedside. Interview on 12/16/25, at 10:23 a.m. Resident R127 indicated using the CPAP machine every night. Interview completed on 12/19/25, at 10:23 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed Resident R127's MDS did not indicate use of the CPAP as required. Review of the RAI User's Manual dated October 2025, indicated the following instructions: -B0700 indicated the definition of making self-understood as able to express or communicate requests, needs, opinions, and to conduct social conversation in their primary language. -B0800 indicated the definition of the ability to understand others as comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Include the resident's ability to process and understand language. Review of the admission record indicated Resident R161 admitted to the facility on [DATE]. Review of Resident R161's MDS dated [DATE], indicated the diagnoses of high blood pressure, diabetes, and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Section B0700 indicated understood. Section B0800 indicated understands - clear comprehension. Section C0500 Brief Interview for Mental Status (BIMS- a screening test that aids in detecting cognitive impairment) score of two severe impairment. Observation on 12/15/25, at 10:18 a.m. Resident R161 was sitting up sideways in a low bed facing the window attempting to get out of bed. Tour and interview on 12/15/25, at 10:19 a.m. with Registered Nurse (RN) Employee E9 indicated Resident R161 as being difficult to redirect and communicate with. Interview on 12/15/25, 10:25 a.m. Nurse Aide (NA) Employee E16 indicated Resident R161 speaks a different language, has dementia, and is very difficult to redirect as resident does not understand or follow instructions well. Interview on 12/19/25, at 12:30 p.m. the Director of Nursing confirmed that Resident R161 was confused and could not make self-understood or (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand others and that the MDS coding was not reflective of the resident's current needs. Interview on 12/19/25, at 12:45 p.m. the Director of Nursing confirmed the facility failed to ensure MDS assessments accurately reflected the resident's status for two of four residents (Resident R127 and R161). 28 Pa. Code 211.12(c)(d)(5) Nursing services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to implement procedures to ensure the timely acquisition and administration of prescribed medications for one of six sampled residents (Resident R109). Findings include: The facility Pharmacy services policy last reviewed 11/1/25, indicated the facility shall accurately and safely provide and obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals. Pharmacy services consist of the residents having a sufficient supply of their prescribed medications and receive those medications in a timely manner. Review of Resident R109's admission record indicated he was originally admitted on [DATE] and re-admitted on [DATE]. Review of Resident R109's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 8/12/25, indicated he had diagnoses that included end stage renal disease (gradual loss of kidney function), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and skin infection. Review of Resident R109's care plans dated 8/6/25, indicated to administer medications as ordered. Review of Resident R109's clinical nurse note dated 9/24/25, indicated per pharmacy, they will not deliver tacrolimus. Review of Resident R109's clinical nurse note dated 10/6/25, call placed to nephrologist about Tacrolimus 0.5mg tabs not available. Resident R109 needs a total of 1.5mg in the morning. Per Nephrologist, it's ok to give one mg one time for now until we receive medication from pharmacy. Call placed to pharmacy, will deliver medication tonight. Review of Resident R109's physician orders indicated the following: -Physician order dated 9/30/25, indicated to give Tacrolimus Oral Capsule 0.5 MG. Give 3 capsule by mouth one time a day for anti-rejection (1.5mg total). -Physician order dated 10/6/25, indicated to give Tacrolimus Oral Capsule 1 mg. Give 1 capsule by mouth one time only for kidney transplant until 10/06/2025, 10:59 may give 1mg capsule, 0.5mg caps not available. -Physician order dated 11/11/25, indicated to give Tacrolimus Oral Capsule 1 mg, Give 1 capsule by mouth two times a day for anti-rejection. Review of Resident R109's Medication Administration Record (MAR) documentation for September, October, and November of 2025 found the following: -9/24/25: at 7:14 a.m. three capsules of Tacrolimus not available. -9/25/25: at 6:37 a.m. three capsules of Tacrolimus not available and pharmacy notified by three nurses. -10/6/25: at 9:25 a.m. One time order written due to dosage (1mg) unavailable -10/7/25: at 10:34 a.m. Tacrolimus 0.5mg was not administered. Only 1mg dose available. Pharmacy called at 9:44 a.m. and Pharmacy said it will be delivered today. -11/9/25: at 12:04 p.m. Medication not available for all doses; pharmacy contacted. -11/9/25, at 9:43 p.m. Tacrolimus. Give one capsule by mouth in the evening for anti-rejection. Not here yet. -11/10/25: 8:51 p.m. Awaiting pharmacy arrival. -11/11/25: at 9:56 a.m. Medication not available During an interview on 12/17/25, at 12:30 p.m. Resident R109 stated the following concerns: I've been here for five months. They scheduled my discharge for tomorrow. I spoke to a nurse about the problems and never spoke to Administration. Pharmacy has caused me to go without my medication Tacrolimus on four occasions. During an interview on 12/18/25, at 9:49 a.m. interview with Certified Registered Nurse Practitioner (CRNP) Employee E14 was asked about Resident R109 missing medication and stated: yes, he has told me about his Tacrolimus, the facility did address it. It was a pharmacy error. Certified Registered Nurse Practitioner (CRNP) Employee E14 was asked how many times the medication was unavailable? it may have happened once or twice. The building addressed it and I have not heard anything recently. It's a specialty medication he receives from his kidney transplant. During an interview on 12/18/25, at 10:05 a.m. Registered Nurse (RN) Employee E15 was asked if she recalled any medications not being available for Resident R109: yes, the Tacrolimus. That was about a month ago. I spoke to the pharmacy. Director of Nursing (DON) was made aware. Pharmacy was made aware. They were supposed to drop ship the medication and only send the 1 mg. The doctor and (continued on next page)		

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Centers for Medicare & Medicaid Services

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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 12/19/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) were made aware. During an interview on 12/18/25, at 10:25 a.m. Contracted Pharmacist Employee E17 was asked about Resident R109 medication: this is concerning the Tacrolimus. The insurance rejection came through with this. One example was on 9/25/25, at 730 a.m. in the morning. The submission for payment was rejected because it was not appropriate for this location. But then the medication was sent out that night at 9/25/25. When asked how often this is happening with insurance: it's more common than is not. Very common; they come to the home and it's a non-covered product and then it becomes a problem. When asked if the facility accountable for making sure medication is here: no. that is on the pharmacy. We have to make sure that the medication is changed. During an interview on 12/18/25, at 2:31 p.m. information disseminated to the Nursing Home Administrator (NHA) and Director of Nursing (DON) that the facility failed to implement procedures to ensure the timely acquisition and administration of prescribed medications for Resident R109 as required. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.9 (f)(2) Pharmacy services.		

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 12/19/2025
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in two of five medications carts (first floor medication cart four and second floor medication cart two) and two of two medication rooms (first floor, and second floor medication rooms). Findings include: Review of the facility policy Medication Labeling and Storage last reviewed 11/1/25, indicated the facility stores all medications and biologicals in locked compartments. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Review of the facility policy Discarding and Destroying Medications last reviewed 11/1/25, indicated medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state and local regulations governing the management of non-hazardous pharmaceutical, hazardous waste and controlled substance. Observation completed on 12/17/25, at 11:07 a.m. of the first-floor medication room the following was discovered: -Area under sink contained one bottle of liquid drug buster. -Area under the sink contained a blue bowl with twenty-two packets of resident medication. -A blue bowl was sitting on top of the refrigerator containing nine packets of resident medication. During an interview completed on 12/17/25, at 11:25 a.m. Registered Nurse (RN) Employee E10 confirmed the medications packs were in the blue bowls and stated, they need to be destroyed. -The refrigerator temperature log revealed the following dates with no recorded temperatures: 12/5/25, 12/9/25, 12/10/25, 12/11/25, 12/12/25, and 12/14/25. Interview completed on 12/17/25 at 11:43 a.m. RN Employee E10 confirmed the temperature logs were not completed as required. Observation completed on 12/17/25, 12:40 p.m. the first-floor medication cart four contained: -A bottle of clearlax opened and without a date -Albuterol inhaler opened without a date -Nasal spray opened without a date -A bottle of liquid Tylenol opened and without a date. (continued on next page)		

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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	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A bottle of Geri- tussin opened and without a date. During an interview completed on 12/17/25 at 12:45 p.m. RN Employee E23 confirmed the above observations. Observation of the second-floor medication room refrigerator on 12/16/25, at 11:32 a.m. revealed an opened TB vial (tuberculin multiple dose vial - a substance used in the tuberculin skin test (TST) to diagnose tuberculosis infection) without a date as required. Interview on 12/16/25, at 11:15 a.m. Registered Nurse (RN) Manager Employee E8 confirmed the TB vial was not dated as required. Observation on 12/16/25, at 12:20 p.m. of the second-floor medication cart number two revealed a bottle of prednisolone acetate one percent suspension (corticosteroid eye drop to reduce inflammation) opened and without a date as required. Interview on 12/16/25, at 12:21 p.m. Licensed Practical Nurse (LPN) Employee E7 confirmed the eye drops were not dated as required. Interview on 12/19/25, at 12:45 p.m. the Director of Nursing confirmed the facility failed to store medications and biologicals properly and securely in two of five medications carts (first floor medication cart four and second floor medication cart two) and two of two medication rooms (first floor, and second floor medication room). 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy 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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, staff, and resident interviews, it was determined that the facility failed to provide residents food products based on their preferences for two of eight residents (Resident R149, R174). Findings include: Review of clinical record indicated Resident R149 was admitted to the facility on [DATE], with diagnoses of diabetes mellitus, morbid obesity and hepatic encephalopathy (brain dysfunction caused by liver dysfunction). Review of Resident R149's MDS dated [DATE], revealed the diagnoses were current. Review of R149 physician's orders dated 12/5/25 indicated allergies to chicken, fish, mushroom, turkey. Interview on 12/16/25 at 10:30 a.m. Resident R149 indicated the kitchen gives her only hamburgers when there is chicken, fish, or turkey on the menu even though they have an always available menu and that her family has to bring her food when there is chicken on the menu. Review of clinical record indicated Resident R174 was admitted to the facility on [DATE], with diagnoses of left femur fracture, protein-calorie malnutrition and dementia. Review of Resident R174's MDS dated [DATE], revealed the diagnoses were current. Review of R174 physician's orders dated 12/14/25 indicated allergies to milk, nuts, peanuts, wheat. Observation of posted lunch meal 12/15/25, consisted of fish sticks, peas and carrots, lemon pudding. Observation of Resident R174's lunch meal on 12/15/25 consisted hamburger on bread, tartar sauce, peas and carrots and lemon pudding. Interview on 12/18/25 at 9:30 a.m. with Registered Dietitian Employee E13 indicated Resident R149 tray cards do not default to another menu item when something that she is allergic to is on the menu and confirmed her tray cards are not individualized to her allergies. Pa Code: 201.14(a) Responsibility of licensee		