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	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Hills Post Acute	1105 Perry Highway Pittsburgh, PA 15237

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, incident reports, facility documents, employee statements, and staff interview it was determined that the facility failed to ensure that a resident received adequate supervision who was an elopement risk which resulted in an elopement for one of seven residents (Resident R1). This was identified for past non-compliance for Resident R1. Findings include: Review of facility policy Elopement indicated: It is the policy of this facility to protect residents from wandering away from the facility and to begin an immediate search if a resident is found missing. Review of Resident R1's admission record indicated they were admitted on [DATE]. Review of Resident R1's MDS assessment (MDS - Minimum Data Set - a periodic review of resident needs) dated 5/27/25, indicated diagnosis of unspecified dementia (a group of symptoms affecting memory, thinking and social abilities) and mood disturbance (disconnect between actual life circumstances and the persons' state of mind or feeling). Review of Resident R1 clinical record BIMS (brief interview for mental status) dated 5/27/25, revealed the resident had a BIMS of 9, meaning moderately cognitively impaired. Review of Resident R1 elopement assessment, indicated Resident R1 total score was a 9 which indicates resident is a wander risk. Review of facility submitted documentation indicated the following: At 10:47PM, Resident R1, BIMS 9, exited the center, without notification, while wearing their wander alarm, via the Grand Heritage doorway (delivery door - equipped with magnetic locks and alarm) to the lower parking lot. Resident was last assessed for elopement risk on 05/22/2025, with wander alarm was indicated, ordered and placed same day. The resident was gone from the facility 14 minutes which included the time that an employee brought back to the center. The resident was appropriately dressed for the weather, fully clothed, to include footwear and the temperature was 76 degrees and the climate was clear and dry. Resident R1 assessed for injury and/or emotional trauma without noted concern. Upon return to the center the resident was reassessed for elopement and transferred to the secure unit. Physician and family notified. Emotional support provided to resident. A full investigation into the matter was launched. Review of facility documentation witness statements indicated the following: LPN Employee E2 stated they were leaving the facility and saw Resident R1 walking across the street, LPN Employee E2 got in her car and escorted Resident R1 back to the facility . LPN Employee E3 after they received a call from the person who dropped them off indicating that they thought a resident was across the street from the facility describing a person wearing pink pants and a yellow shirt walking back and forth. They identified the person as Resident R1 - went to get the resident from across the street and as they were in the parking lot they saw an LPN Employee E2 bringing them back. Maintenance Assistant Employee E4 indicated that on 7/3/25, they exited out of the building through the delivery door (door which was identified that Resident R1 eloped from). During an interview on 7/16/25, at 9:30 a.m. NHA (Nursing Home Administrator) confirmed that the facility failed to ensure that a resident received adequate supervision who was an elopement risk which resulted in an elopement for one of seven residents (Resident R1). This was identified for past non-compliance for Resident R1. The facility implemented a plan of correction that included the following: Resident R1 was assessed and no injury was identified. Resident R1 was appropriately dressed and did not appear to suffer any emotional trauma after incident. Resident R1 was transferred to facility secure unit with family approval. At the time of the event the delivery door was determined to be open and the system was re-engaged.A whole house audit was completed. All residents accounted for. All doors were checked to ensure they were secure. Facility had in place a system checking all door locks to make sure they were properly functioning During a review of facility documentation of Door Mag Lock check list, indicated that the door locks were function appropriately on the following days:5/23/255/29/256/04/256/13/256/20/256/24/257/03/25 Facility elopement plan was updated to include use of designated exit doors only by employees and placement of transponders on residents identified at risk for elopement. To prevent a risk of recurrence of elopement plan will be updated to include transponder placement on residents at risk for elopement and designated employee entrances. A sign will be placed on the delivery door that it is only for deliveries and emergency use. All employees will receive education and return competency on safety and elopement risk reduction strategies, and all new hires will receive the same education/competency moving forward. The center will have all the doors checked by the alarm company. Maintenance Director will increase door transmitter frequency to 4ft distance. Maintenance Director/designee will complete door checks daily for 1 week, weekly for 3 weeks and monthly thereafter for operation of door