

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2025
NAME OF PROVIDER OR SUPPLIER  Redstone Highlands Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  6 Garden Center Drive Greensburg, PA 15601	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on review of policies, manufacturer's operations manual, clinical records, and facility reports, as well as staff interviews, it was determined that the facility failed to ensure residents' environment remained free of accident hazards, and failed to ensure adequate interventions and supervision to prevent elopements which threatened the resident's safety and increased the resident's risk for accidents and bodily injury or harm for one of three residents identified at risk for elopement (Resident 3). The facility further relied on its alarm system to prevent unsupervised exits, which placed residents in immediate jeopardy of the likelihood of serious bodily injury, harm or death. This deficiency was cited as past non-compliance. Findings include: The facility policies for elopements and Wander Guards (a bracelet that triggers an alarm and can lock monitored doors to prevent the resident from leaving unattended), dated July 11, 2025, indicated that an Elopement Risk Observation would be completed by a licensed nurse upon admission, re-admission, and/or with any significant change in status whereby an elopement may become an increased possibility. Upon completion of an Elopement Risk Observation, it would be determined by the charge nurse as to what interventions would be initiated. Upon determination of appropriate interventional devices to be utilized to maintain resident safety, a physician order would be obtained for any such device. Upon high risk determination, the resident would be issued a Wander Guard bracelet to be placed on his/her wrist or ankle. Placement of the Wander Guard apparatus would assist in alerting interdisciplinary team members that a resident has, or is attempting to exit the nursing unit. All residents having orders for, or utilizing the Wander Guard bracelet, would have placement and function assessed every shift while awake and out of bed to chair. Individual care plans would be updated accordingly. If a resident eloped and was found, staff were to notify the Nursing Home Administrator, Director of Nursing, Executive Director, [NAME] President of Quality Services, Director of Building Services, and the responsible party when the resident was found. Nursing would complete a head to toe assessment, provide appropriate immediate care, if warranted, and document the findings and details of the episode in the resident's medical record. Nursing staff would complete a n internal incident report and communicate a shift to shift report for the next 72 hours regarding the resident's condition. Nursing Administration would notify the State Department of Health following initial steps to address the emergency. The operator's manual for the wanderer monitoring system, undated, indicated that wander monitoring transmitters should be tested daily for proper operation. If a device was in a low battery state, the battery or device was to be replaced as soon as possible. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 1, 2025, indicated that the resident could usually make her self understood and understand others, was cognitively impaired, used a wander/elopement alarm, and had diagnoses that included dementia. Current physician's orders for Resident 3, included orders for a wander guard to be used and its function and placement checked every shift. A care plan, dated July 11, 2024, indicated the resident was to use a wander guard and have the placement checked every shift. A social service note, dated April 8, 2025, revealed that Resident 3 required a wander guard due to her making her way down the elevator at times. An elopement assessment, dated September 2, 2025, revealed that Resident 3 was at risk for elopement. A nursing note for Resident 3, dated September 16, 2025, at 8:01 p.m. revealed the resident was escorted back into the building by EMS (Emergency Medical Services) personnel from the back entrance and she was unable to explain why she was out there. A wander guard was attached to her Broda chair (specialized wheelchair). A facility investigation, dated September 17, 2025, revealed that on September 16, 2025, at 2:52 p.m. Resident 3 eloped by accessing the elevator, going down to the ground floor, headed to personal care, and left the facility. The resident self propels in her wheelchair around the unit. Administration was notified of the elopement on September 17, 2025, at 8:30 a.m. and upon checking Resident 3's wander guard, it was noted in the system as of 6:45 a.m. in the morning that her battery status was low. Resident 3's wander guard was changed immediately upon notification and an elopement assessment was completed on all residents. A Treatment Administration Record (TAR) for September 2025 revealed that on September 16, 2025, staff charted - for the wander guards functioning for the first, second, and third shift. A system status report, dated September 16 and 17, 2025, revealed that Resident 3's wander guard battery status was low for these days. A witness statement from Registered Nurse 1, dated September 17, 2025, revealed that around 3:50 p.m. EMS brought Resident 3 back to the unit and reported that she was outside by receiving and she notified the resident's nurse immediately. A witness statement from Registered Nurse 2 dated September 17, 2025</p>		