

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Highland Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4285 South Highland Drive Holladay, UT 84124	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible, and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 2 out of 41 sampled residents, two residents eloped from the facility that required supervision. Resident identifiers: 55 and 68. Findings included: 1. Resident 55 was admitted to the facility on [DATE] with diagnoses which included, Parkinson's Disease with dyskinesia, unsteadiness on feet, other abnormalities of gait and mobility, cognitive communication deficit, and cognitive communication deficit. The facility reported to the State Survey Agency on 5/7/26 at 5:30 AM, that resident 55 was unable to be located in the facility. Facility staff initiated a search of the facility and a Certified Nursing Assistant (CNA) reported seeing resident 55 running down the north hallway toward the stairwell area. Around 6:10 AM, a CNA coming to work identified resident 55 walking down a high-traffic street and transported resident 55 back to the facility. A wandering assessment completed on 4/16/26, documented that resident 55 scored a 13 which indicated a high risk for wandering. An admission Minimum Data Set assessment dated [DATE], revealed that resident 55 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. Resident 55's progress notes revealed the following: a. On 4/16/26 at 2:18 AM, a 72 hour admission charting note documented, .Has had some episodes of wandering and elopement attempts, has a new wanderguard d/t [due to] this. Resident confused. b. On 4/24/26 at 7:03 PM, a nurses note documented, .resid [resident] noted this afternoon X [times] 1 to get out of the facility and found by therapist walking in the front parking lot-redirected backinto [sic] facility and cont [continue] frequent checks. c. On 4/25/26 at 8:18 PM, a nurses note documented, .resid has been more calm this shift, walking up/down mostly north hall, occas [occasionally] to south, sometimes going to front door, looking out, (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/26, a physician's order documented Monitor wander guard placement and function. Check skin is free from breakdown r/t [related to] placement. two times a day. On 5/13/26 at 2:22 PM a BIMS Evaluation documented that resident 68 had a BIMS score of 99. A BIMS score of 99 indicated that the resident was unable to complete the interview. On 5/14/26 at 4:52 PM, an Elopement Evaluation documented that resident 68 had a history of elopement while at home. Resident 68 wanders and the wandering behavior was a pattern or goal-directed. Resident 68 had an elopement Score of 5.0. [It should be noted that an elopement risk score of 5 generally indicates that a resident meets the threshold for being at risk for wandering or leaving a facility unsupervised.] On 6/15/26 at 1:23 AM, a Nurses Note documented Resident had an incident last evening 6/14/26 around 7:15pm where wife's brother and some other visitors were seeing [resident 68] and his wife and when they left, [resident 68's] wife [name redacted] found staff and stated that her husband had followed the visitors and that she could not locate him. Staff looked for [resident 68] and he was ultimately located by staff outside the building and brought back inside without incident.[Name redacted] and the nurse on duty called the visitors at 7:23pm and gave education to them, visitors stated that they had not let [resident 68] out but that they had seen him following someone who was delivering food to the building but agreed that next time they visited they would make sure that [resident 68] was safe inside of his room when they left. Administrator [name redacted] of incident at 7:20pm via telephone. The June 2026 Medication Administration Record [MAR] was reviewed. The MAR documented that resident 68 had a wander guard in place and staff were checking placement and function every shift. On 7/22/26 at 12:08 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated if a resident had a wander guard the door would alarm when the resident would get too close and the door would alarm until the resident moved. RN 2 stated that she was not sure it was functioning because she had tested another resident's wander guard that day and the door only alarmed for a minute. RN 2 stated the wander guard alarm system was the same throughout the facility at all of the exit doors. On 7/22/26 at 12:32 PM, an interview was conducted with the Admin. The Admin stated that residents were reviewed on admission for elopement risk. The Admin stated the staff also did a community assessment to ensure the residents were safe to go out in the community. The Admin stated if a resident with a wander guard got close to the door the alarm would alert the staff and the staff would have to enter a code to turn the alarm off. The Admin stated there was a time when resident 68 left the facility with friends and family. The Admin stated it was reported to him that resident 68 had followed family out of the facility and that same family had seen resident 68 and brought him back into the facility. The Admin stated that resident 68 should have had a wander guard on but resident 68 had a wander guard on now. The Admin stated if a door was open the door would alarm but resident 68 would still be able to get out. The Admin stated that resident 68 could also get out if the door did not fully latch. The Admin stated if a door was open or not latched the alarm should still alert staff that someone was outside and the staff would need to enter the code to turn off the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alarm. The facility policy Elopements and Wandering Residents was reviewed. Policy: This facility ensured that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents as Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.		