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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375172 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER Southern Hills Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 5170 South Vandalia Tulsa, OK 74135 | |

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) |
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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>1. On 04/21/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to supervise residents with exit seeking behaviors.</p> <p>On 04/14/25 Resident #14 was observed to leave the courtyard by a resident, from an unlocked gate, staff were notified and were able to redirect Resident #14 back into the building.</p> <p>Based on record review and interview, the facility failed to provide supervision for 1 (#14) of 1 sampled resident reviewed for exit seeking behaviors.</p> <p>The DON identified 66 residents resided at the facility.</p> <p>Findings:</p> <p>An elopement evaluation, dated 03/27/25, showed Resident #14 was at risk for elopement. The evaluation showed Resident #14 wandered aimlessly and the behavior was likely to affect the safety or well-being of self or others.</p> <p>A care plan, dated 03/28/25, showed Resident #14 liked to go to the courtyard and staff were educated to keep an eye as they passed by.</p> <p>An un-witnessed fall incident report, dated 03/29/25, showed Resident #14 had a history of wandering.</p> <p>An elopement evaluation, dated 04/04/25, showed Resident #14 was at risk of elopement. The evaluation showed Resident #14 had a history of elopement or an attempted elopement while at home and the facility without informing staff, but had not verbally expressed the desire to go home or stay near an exit door.</p> <p>A re-admission assessment, dated 04/10/25, showed a BIMS assessment was not completed due to memory problems for both long and short-term memory. The assessment showed Resident #14 had severely impaired cognitive skills for daily decision making. The assessment showed diagnoses which included a history of stroke and traumatic brain injury.</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.

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| 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>A care plan, revised 04/11/25, showed Resident #14 had a concern for wandering/elopement with episodes of wandering on and off the unit. The care plan showed interventions which included to educate staff to redirect and assist Resident #14 to their hall when observed heading to the doors, ensure Resident #14 was inside the premises by checking on them every two hours and as needed, educate staff to be mindful when going out if Resident #14 was close by or following, and engage Resident #14 in purposeful activity.</p> <p>An elopement incident report, dated 04/14/25, showed Resident #14 had exited the courtyard through an unlocked gate that had been propped open by contractors. The report showed Resident #14 had a predisposing situation factor of Active Exit Seeker. The report showed Resident #14 had stated they wanted out of there.</p> <p>A care plan, revised 04/14/25, showed one-on-one observation every shift and to document in the clinical record.</p> <p>In-service documentation and the ad hoc QAPI meeting signature sheet for elopement and resident safety dated 04/18/25 were reviewed. The documents confirmed in-services and the ad hoc QAPI meeting were completed.</p> <p>On 04/17/25 at 2:53 p.m., the DON stated Resident #14 was sent to a psychiatric hospital, then would be going to a locked unit.</p> <p>On 04/21/25 at 10:32 a.m., the administrator stated they placed signs on the doors to not let residents out of the building and spoke with the contractors about not propping doors open. The administrator stated no other residents were at risk for elopement. They stated Resident #14 was placed on one-on-one supervision until Resident #14 was transferred to a psychiatric hospital, then went go to a locked unit. The administrator stated an ad-hoc QAPI meeting took place and a preventative intervention plan was developed which included the one-on-one supervision. The administrator stated they monitored the documentation daily in the electronic clinical record for Resident #14.</p> <p>On 04/21/25 at 11:45 a.m., CNA #1 stated they believed Resident #14 had dementia. They stated they never saw Resident #14 try to get out, but had been informed Resident #14 was a wanderer and exit seeker. CNA #1 stated they were informed to keep an eye out when Resident #14 went to the courtyard.</p> <p>On 04/21/25 at 11:51 a.m., CNA #2 stated Resident #14 had memory issues and would forget things like to lock their wheelchair. They stated staff had to keep watch when Resident #14 went outside the gate by supervising one-on-one.</p> <p>On 04/21/25 at 11:54 a.m., LPN #1 stated Resident #14 was very confused, easily agitated, and a wanderer. LPN #1 stated Resident #14 was an exit seeker and one-on-one supervision was implemented when they eloped. LPN #1 stated the DON told them to after Resident #14 eloped. LPN #1 stated they were not aware of Resident #14 needing one-on-one before they eloped. LPN #1 stated Resident #14 eloped on 04/14/25 around 1:30 p.m. and was sent out on 04/15/25.</p> <p>2. On 05/14/25 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure the safety of exit seeking residents.</p> <p>(continued on next page)</p> |

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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>An incident report, dated 05/14/25, showed a representative of Resident #15 approached staff on 05/13/25 at 7:30 p.m. and asked where they could find Resident #15. The report showed staff did not know Resident #15 was missing. Facility protocol was followed for missing residents and Resident #15 was found four minutes later in the facility's independent living [NAME] parking lot. The form showed another resident witnessed Resident #15 leave the courtyard through the gate.</p> <p>On 05/14/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 05/14/25 at 2:46 p.m., the DON and the corporate regional administrator were notified of the IJ situation and provided the IJ template.</p> <p>On 05/15/25 at 10:22 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>Deficiency Summary: Resident #15 was able to elope the courtyard without staff intervening which put Resident #15 at risk of serious harm or death. During a tour of the courtyard on 05/14/25 at 11:02 a.m., the gates on the east and west side of the courtyard were observed to have a key lock on the latches of the gates that were unlocked. The lock was removed and the gate opened, leading to the parking lot on the east side of the building. This continued to be a hazard for all mobile residents in the facility.</p> <p>1.</p> <p>Immediate Action Taken:</p> <p>a.</p> <p>When resident #15 was reported missing, an elopement drill was implemented and resident was found within [four] minutes.</p> <p>b.</p> <p>Resident #15 was immediately place[sic] on One on One until [Resident #15] was transferred to another lock down facility for [their] safety.</p> <p>c.</p> <p>Staff monitored the courtyard and courtyard was secure at 12:30 pm on 5/14/2025.</p> <p>2.</p> <p>Systemic Changes Implemented:</p> <p>a.</p> <p>Courtyard gates were secured with combination locks on 5-14-2025 at 1230pm</p> <p>(continued on next page)</p> | | |

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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>b.</p> <p>Staff have been in-service[sic] not to use gates in courtyard.</p> <p>c.</p> <p>Elopement assessments have been completed on all residents, and the elopement book has been updated.</p> <p>3.</p> <p>Education and Training</p> <p>a.</p> <p>In-service of all staff on the following: Completed on 5-15-2025 at 6:30am</p> <p>i.</p> <p>No entry or exit out of the courtyard gates.</p> <p>ii.</p> <p>Elopement Book (location)</p> <p>iii.</p> <p>Elopement and wandering residents' policy and procedures</p> <p>iv.</p> <p>Residents & families enter and exit through the main entrance.</p> <p>Facility will be in compliance on 5-15-2025 at 6:30am.</p> <p>The IJ was lifted, effective 05/15/25 at 6:30 a.m., when all components of the plan of removal had been verified as completed. The gates on the East and [NAME] side of the courtyard were observed to be locked with combination locks. In-services regarding resident elopement and safety were reviewed and staff were interviewed to ensure in-service was completed. Elopement assessments were reviewed for residents in the facility to ensure assessments were completed and the elopement book was observed to have been updated. The deficient practice remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on observation, record review and interview, the facility failed to ensure the safety for 1 (#15) of 2 sampled residents reviewed for exit seeking residents.</p> <p>The DON identified 66 residents resided at the facility and no current residents were at risk for elopement.</p> <p>(continued on next page)</p> |

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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>Findings:</p> <p>On 05/14/25 at 11:02 a.m., the East and [NAME] gates of the courtyard were observed to have open key locks on the latches of the gates. The key lock was removed from the East gate and the gate opened up to the East parking lot.</p> <p>On 05/14/25 at 11:04 a.m., the west gate was observed to have an open key lock on the gate, the key lock was removed, and the gate required force to be opened.</p> <p>On 05/14/25 at 11:06 a.m., a ramp at the back of the facility courtyard was observed going up to an open patio for assisted living residents. The patio was observed to have an open area to the [NAME] of the patio where a piece of fencing was removed. The area to the [NAME] of the patio was observed to lead to the independent courtyard and at the front of the independent courtyard was an unlocked gate leading out to the independent parking lot.</p> <p>An admission assessment, dated 02/07/25, showed a BIMS of 00 and a staff assessment for mental status was not conducted. The assessment showed diagnoses which included a traumatic brain injury, aphasia (a language disorder that affects a person's ability to communicate) and depression. The assessment showed functional abilities which included no impairment to upper extremities but impairment on both sides of the lower extremities and Resident #15 was dependent for mobility with a wheelchair but could stand with assistance.</p> <p>A progress note, dated 05/12/25 at 3:24 p.m., showed an elopement evaluation was completed. The evaluation note showed Resident #15 had wandering behavior that was a pattern or goal-directed and was likely to affect the safety or well-being of self or others.</p> <p>A progress note, dated 05/12/25 at 10:21 p.m., showed Resident #15 was propelling around the facility and stated they were leaving and attempted to exit the door. The note showed Resident #15 stated people were waiting for them and they needed to leave, multiple redirects and checks for safety followed.</p> <p>An incident report, dated 05/14/25, showed a representative of Resident #15 approached staff on 05/13/25 at 7:30 p.m. and asked where they could find Resident #15. The report showed staff did not know Resident #15 was missing. Facility protocol was followed for missing residents and Resident #15 was found four minutes later in the facility's independent living [NAME] parking lot. The form showed another resident witnessed Resident #15 leave the courtyard through the gate.</p> <p>A care plan, revised 05/14/25, showed Resident #15 was noted to be outside of the facility and an elopement drill was initiated. The care plan showed Resident #15 was placed on one-on-one supervision with staff.</p> <p>(continued on next page)</p> | | |

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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>On 05/14/25 at 10:11 a.m., the interim administrator was asked if the facility had an incident on 05/13/25. They stated Resident #15 went out to the courtyard and out of the [NAME] gate to the independent living courtyard and into the parking lot. They stated the immediate action was to place Resident #15 on one-on-one with staff. The interim administrator stated the DON called them on the night of 05/13/25 and informed them another resident saw Resident #15 go out the gate. They stated Resident #15 left the courtyard through the gate on the [NAME] side and was aware enough to know how to open the gate. The interim administrator stated they were locking the gates and the keys were on the medication cart and nurses keys until they could have a keypad installed. They stated nobody was going in or out the gates until the facility had the keypad installed. They stated they were in-servicing all staff on 05/14/25 and looking for a lock down facility for Resident #15 following a discussion with the representative of Resident #15. The interim administrator stated Resident #15 did not leave their facility grounds and the gates had dummy locks, locks that were not completely locked, because they were under the impression it would be a life safety issue.</p> <p>On 05/14/25 at 12:57 p.m. the DON stated Resident #15 had eloped from the [NAME] gate and entered the independent courtyard and exited the unlocked gate out into the parking lot. They stated the resident who witnessed the elopement was Resident #16, who was also in the courtyard at the time.</p> <p>On 05/14/25 at 2:39 p.m., Resident #15's representative stated the facility was not holding the nurse accountable. They stated the nurse informed them Resident #15 used a code to exit the facility. They stated they knew Resident #15 could not do that. Resident #15's representative stated they felt like the DON had a problem with them and that was why the facility wanted to transfer Resident #15 to a different facility.</p> | | |