STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375172	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Hills Rehabilitation Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the state agency within the 2 hour required time frame for 2 (#2 and #5) of 3 sampled residents reviewed for abuse.The DON identified 67 residents resided in the facility.Findings: A facility policy titled ABUSE PREVENTION POLICY & PROCEDURE, revised 05/23/17, read in part, Any allegation of abuse is reported immediately to the state agency and to all other agencies as required, per state and federal guidelines. Immediately means as soon as possible, but should not exceed 24 hours after the discovery of the incident, in absence of a shorter state timeframe requirement. Refer to State, Federal and Elder Justice Act guidelines. 1. An undated face sheet showed Res #2 had diagnoses which included multiple sclerosis, age related osteoporosis, contractures, and muscle wasting and atrophy.Res #2's quarterly assessment, dated 04/21/25, showed the residents cognition was intact and a BIM score of 15.An OSDH incident report, with an incident date of 06/06/25, showed on 06/09/25 at 12:45 p.m. the resident reported to the DON, CNA #4 had left them in their room with the door shut. The report showed the resident had been incontinent of bowel and bladder and was uncomfortable to the point of pain. The report showed Res #2 was afraid with the door closed. A fax transmittal page, dated 06/09/25 at 7:05 p.m., showed the state agency was notified of the allegation of abuse regarding Res #2. The facility failed to report to the state agency within the two-hour required time frame.On 07/10/25 at 3:15 p.m., the DON reviewed the investigative documentation regarding the allegation of abuse on 06/06/25 for Res #2. The DON stated the incident was not reported to the state agency within the two-hour required timeframe.2. An undated face sheet showed Res #5 had diagnoses which included acute respiratory failure, seizures, spinal stenosis, and paranoid schizophrenia.An OSDH incident report, dated 06/29/25, showed an allegation of abuse. The report showed the physician, family, and DHS: Adult Protective Services were notified. The report showed on 06/30/25, the family of Res #5 reported to the administrator Res #5 had been spoken harshly to by CNA #5. On 07/10/25 at 3:15 p.m., the DON reviewed the documentation regarding the allegation of abuse for Res #5. The DON stated they could not find documentation the state agency was notified of the incident within the 2-hour required timeframe.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375172	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Hills Rehabilitation Center	5170 South Vandalia Tulsa, OK 74135

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 2 (#2 and #5) of 3 sampled residents reviewed for abuse.The DON identified 67 residents resided in the facility. Findings: A facility policy titled ABUSE PREVENTION POLICY & PROCEDURE, revised 05/23/17, read in part, Any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect, whether physical, verbal, mental or sexual, involuntary or voluntary, is to be thoroughly reported, investigated and documented in a uniform manner as detailed below. An incident of abuse incident of abuse must be reported to the charge nurse who will examine the resident, document findings in the clinical records an immediately initiate the Investigation protocol.1. An undated face sheet showed Res #2 had diagnoses which included multiple sclerosis, age related osteoporosis, contractures, and muscle wasting and atrophy.Res #2's quarterly assessment, dated 04/21/25, showed the residents cognition was intact with a BIM score of 15.An OSDH incident report, with an incident date of 06/06/25, showed on 06/09/25 at 12:45 p.m. Res #2 reported to the DON that CNA #4 left them in their room with the door shut. The report showed the resident had been incontinent of bowel and bladder and was uncomfortable to the point of pain. The report showed Res #2 was afraid with the door closed. The investigation documentation for the incident on 06/06/25 regarding Res #2 did not contain resident statements or staff statements regarding the allegation of abuse.On 07/10/25 at 3:15 p.m., the DON reviewed the investigative documentation regarding the allegation of abuse on 06/06/25 for Res #2. The DON stated the incident was not thoroughly investigated.2. An undated face sheet showed Res #5 had diagnoses which included acute respiratory failure, seizures, spinal stenosis, and paranoid schizophrenia.An OSDH incident report, with an incident date of 06/29/25, showed an allegation of abuse. The report showed the family of Res #5 reported to the administrator on 06/30/25, CNA #5 was heard speaking harshly to Res #5.The investigation documentation for the incident regarding Res #5 did not contain resident statements or staff statements regarding the allegation of abuse.On 07/10/25 at 3:15 p.m., the DON reviewed the documentation regarding the allegation of abuse for Res #5. The DON stated the incident regarding Res #5 was not thoroughly investigated.