STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375489	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottage Extended Care	7707 South Memorial Drive Tulsa, OK 74133

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. On 05/29/25 at 4:40 p.m., the OSDH was notified and verified the existence of a past non-compliance immediate jeopardy (IJ) situation related to the facility's failure to ensure wound care was completed as ordered. On 05/29/25 at 4:47 p.m., the administrator was notified of the immediate jeopardy (IJ) situation. The administrator was provided the IJ template Based on record review and interview, the facility failed to ensure a resident had wound care completed as ordered for 1 (#1) of 3 sampled residents reviewed for wound care. The DON identified 10 residents received wound care. Findings: A quarterly assessment, dated 02/07/25, showed Resident #1 had a brief interview for mental status score of 11, which indicated moderate impairment in cognitive ability, and had diagnoses which included chronic obstructive pulmonary disease and cognitive communication deficit. A physician order for Resident #1, dated 05/08/25, showed daily dressing changes for left medial ankle venous wound. A progress note, dated 05/27/25 at 1:18 a.m., showed LPN #1 changed the ankle dressing for Resident #1 because it was saturated. LPN #1 removed the soiled dressing and found live maggots in the wound. LPN #1 sought assistance from RN #1 who called the on-call physician, the DON, family, and hospice. Orders were received to send the resident to the hospital. A facility incident report, dated 05/27/25, showed LPN #1 found maggots in Resident #1's leg wound. Documentation showed the facility completed staff in-service regarding abuse on 05/27/25. A quality assurance meeting was held on 05/29/25 regarding abuse and wound care. All staff were educated on neglect on 05/27/25. All nursing staff were educated on wound care on 05/27/25. A head to toe assessment and an abuse neglect survey was conducted for all residents on 05/27/25. The DON began daily monitoring of all wound care to ensure it was being completed as ordered beginning on 05/27/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/29/25 at 1:42 p.m., the administrator stated there was no documentation for wound care for Resident #1 for several days and they had suspended all three nurses who were responsible for wound care. The administrator stated they had visited Resident #1 in the hospital, but Resident #1 did not have a reliable memory as the resident had insisted they had received wound care on 05/26/25. On 05/29/25 at 2:57 p.m., the DON stated a review of wound documentation for Resident #1 showed wound care had not been completed for five days. The facility had terminated the three staff members who had failed to complete wound care during this time period. On 05/30/25 at 3:14 p.m., LPN #1 stated on 05/27/25 just after midnight, they went to assist Resident #1 and noticed their ankle dressing was soiled and saturated through the sock that was covering the dressing. LPN #1 stated when they removed the sock, they could see the date on the dressing was 05/22/25. They removed the soiled dressing and found maggots in the wound bed. LPN #1 stated they asked RN #1 for assistance, RN #1 called the on-call physician, the family, the DON and hospice. LPN #1 stated the physician gave orders to send the resident to the hospital which they did immediately.