

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 37D2088219	(X3) Date Survey Completed 07/22/2026
Name of Provider or Supplier Labcorp Oklahoma, Inc Cityplex	Street Address, City, State 2408 E 81st St, Ste 105, Tulsa, OK	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies
D0000	The recertification survey was performed on 07/20/2026 through 07/22/2026. Standard-level deficiencies were cited.
D3025	REQUIREMENTS FOR TRANSFUSION SERVICES CFR(s): 493.1103(d) Investigation of transfusion reactions. The facility must have procedures for preventing transfusion reactions and when necessary, promptly identify, investigate, and report blood and blood product transfusion reactions to the laboratory and, as appropriate, to Federal and State authorities. This STANDARD is not met as evidenced by: Based on a review of records, policies and procedures, and interview with technical consultant #1, the facility failed to ensure written policies were followed for preventing transfusion reactions for one of seven units reviewed. Findings include: (1) On 07/21/2026 at 2:30 pm, technical consultant #1 stated that the laboratory routinely performed blood transfusions; (2) A review of the policy "Blood Product Administration" defined the parameters for ensuring blood products are transfused safely and stated, "The blood must be completed within four hours of check-out from the lab"; (3) A review of transfusion records for seven units of blood transfused with technical consultant #1 identified for one of seven units transfused, the policy was not followed by nursing personnel: (a) Unit #W091026199214 - The unit was checked out from the blood bank at 03:10 am and was completed at 07:30 am, exceeding the four hour window. (4) Interview with technical consultant #1 on 07/21/2026 at 02:30 pm confirmed the facility failed to ensure the policy was being followed as written.
D5401	PROCEDURE MANUAL CFR(s): 493.1251(a) (a) A written procedures manual for all tests, assays, and examinations performed by

the laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory's written procedures for testing or examining specimens.

This STANDARD is not met as evidenced by:

Based on a review of records, policies and procedures, and interview with the Lead Technologist and the Laboratory Manager, the laboratory failed to follow their policy for establishing the Quality Control limit range % for new lot number of control materials prior to implementation for three of nine lot numbers for the Complete Blood Count (CBC) testing during the review period of February 2026 through the current date, and the laboratory failed to follow their policy for performing correlation studies for the EPOC test system during the review period of January 2026 through the current date. Findings include: I. CBC QC LOT PARALLEL RUN (1) On 07/20/2026 at 10:15 am, the Lead Technologist stated the following: (a) The laboratory performed Complete Blood Count (CBC) testing using the Sysmex XN-1000 analyzer; (b) Three levels of XN-CHECK Quality Control (QC) materials were tested every eight hours of patient testing; (c) Sysmex evidence-based control limits were used to set the quality control limit range %. (2) A review of the procedure manual titled "Sysmex XN-Series Quality Control Policy" under section I. "Commercial Controls", Part - 3. "Target Evaluation of New Commercial Quality Control Lots" stated the following: (a) "a. Parallel testing of all levels of new lot number of commercial controls with current (in-use) lot number of commercial controls will be performed."; (b) "Parallel testing of new control will be performed a minimum of 2 times per day for a minimum of 5 days."; (c) "After a minimum of 10 data points have been established (see step b above) the target value is set for each parameter". (3) A review of records from February 2026 through the current date identified the laboratory failed to follow their policy for implementing new lot of QC materials for three of nine lot numbers reviewed: (a) Low-level Lot #61381101, Normal-level Lot 61381102, and High-level Lot 61381103 - No evidence the QC materials had been parallel tested prior to implementation on 06/01/2026; (4) The findings were reviewed with the Lead Technologist who stated on 07/21/2026 at 10:30 am, the laboratory did not follow their written policy. II. EPOC INSTRUMENT COMPARISONS (1) On 07/20/2026 at 10:50 am, the Laboratory Manager and the Lead Technologist stated the following: (a) Blood gas (pH, pCO₂, pO₂), Sodium (Na), Potassium (K), Chloride (Cl), CO₂, BUN, Creatinine, Ionized Calcium, Glucose, Hemoglobin, and Hematocrit testing were performed using the Siemens EPOC analyzers (SN# 28949 and SN# 35059) and BGEM test cards; (b) The laboratory performed instrument-to-instrument comparisons at least every six months. (2) A review of Policy title "EPOC QC-QM Policy" under section VI. Part A. stated Instrument-to-instrument comparisons will be performed at least every six months and at least five samples will be used for the correlations. (3) A review of records from January 2026 through the current date identified the laboratory failed to follow their written policy for performing instrument-to-instrument comparisons as follows: (a) Although the comparison had been performed on 06/08/2026, the laboratory used four samples instead of five samples as required by policy. (4) The findings were reviewed with the Laboratory Manager who stated on 07/21/2026 at 10:30 am, the laboratory had not followed their policy for performing correlation studies for the EPOC test system. 48517 Based on a review of the policy and procedure manual and interview with technical consultant #1, the laboratory failed to follow written procedures for Complete Blood Count (CBC) testing for one of one patient report and issuing blood from a cooler for three of three units reviewed. Findings include: I. CBC Testing (1) On 07/22/2026 at 10:00 am, technical consultant #1 stated CBC testing was performed on the Sysmex XN-1000

	hematology analyzer; (2) A review of the written procedure titled, "Peripheral Blood Smear Examination" stated, "Count 100 leukocytes"; (3) A review of one patient record identified laboratory staff had not followed their written procedure as follows: (a) Patient reported on 07/8/2026 at 08:07 am - 103 Leukocytes were counted, not 100 as the policy defines. (4) The findings were reviewed with technical consultant #1 who stated on 07/22/2026 at 10:30 am the procedure had not been followed as indicated above. II. Issue Blood From Cooler (1) On 07/21/2026 at 11:00 am, technical consultant #1 stated that the lab used coolers to issue blood occasionally; (2) A review of the written procedure titled, "Packing a Cooler" stated, "The issuer will record the following on the log sheet that accompanies the cooler"; (a) Date/Time (b) Temperature (c) Unit number (d) Issuer's initials (3) For three of three units of blood given from the cooler there was no documentation of the time and date; (4) The findings were reviewed with technical consultant #1 who stated on 07/21/2026 at 11:00 am the procedure had not been followed as indicated above.
D5437	CALIBRATION AND CALIBRATION VERIFICATION CFR(s): 493.1255(a) (a) Unless otherwise specified in this subpart, for each applicable test system the laboratory must perform and document calibration procedures-- (a)(1) Following the manufacturer's test system instructions, using calibration materials provided or specified, and with at least the frequency recommended by the manufacturer; (a)(2) Using the criteria verified or established by the laboratory as specified in 493.1253(b)(3)-- (a)(2)(i) Using calibration materials appropriate for the test system and, if possible, traceable to a reference method or reference material of known value; and (a)(2)(ii) Including the number, type, and concentration of calibration materials, as well as acceptable limits for and the frequency of calibration; and (a)(3) Whenever calibration verification fails to meet the laboratory's acceptable limits for calibration verification. This STANDARD is not met as evidenced by: Based on observation, review of manufacturer's instructions, and interview with the Cath Laboratory manager, the laboratory failed to follow the manufacturer's instructions for using the correct cuvette path length for one of one lot number of cuvettes. Findings include: (1) On 07/22/2026 at 11:00 am, the Cath Laboratory manager stated the laboratory performed Oxyhemoglobin Fraction, Total Hemoglobin Concentration, and Oxygen Content using the Avoximeter 1000E analyzer; (2) An observation during laboratory tour identified the Avoximeter 1000E was calibrated using cuvette pathlength of 116 micrometers and used for patient testing; (3) A review of the package insert for the cuvettes currently in use (lot # 10237751) identified the pathlength was 115 micrometers. (4) A review of the Avoximeter 1000E Operator's Manual, page 6 titled, "Cuvette Pathlength" stated the following: (a) "Accuracy of total hemoglobin measurements depends on using the correct cuvette pathlength (see page 1). The user must check the pathlength whenever using a different lot number of cuvettes"; (b) "The cuvette lot number and pathlength are included on the carton label and bag for each lot of cuvettes". (5) The findings were reviewed with the Cath Laboratory manager, who on 07/22/2026 at 11:04 am confirmed the incorrect cuvette pathlength had been used and manufacturer instructions for calibration had not been followed.
D5783	CORRECTIVE ACTIONS CFR(s): 493.1282(b)(2)

(b)(2) Results of control or calibration materials, or both, fail to meet the laboratory's established criteria for acceptability. All patient test results obtained in the unacceptable test run and since the last acceptable test run must be evaluated to determine if patient test results have been adversely affected. The laboratory must take the corrective action necessary to ensure the reporting of accurate and reliable patient test results.

This STANDARD is not met as evidenced by:

Based on a review of records and interview with technical consultant #1, the laboratory failed to ensure corrective actions were taken when quality control (QC) results failed to meet the criteria for acceptability for four of 24 weeks; Findings include: I. Daily Optical QC (1) On 07/21/2026 at 11:35 am, technical consultant #1 stated the following: (a) tHB and %O2Hb (total hemoglobin and percent oxyhemoglobin) testing were performed using the Avoximeter analyzer; (b) Optical QC to include tHb yellow were performed daily with patient testing; (c) The range of acceptability for tHb yellow was 7.7 - 8.3. (2) A review of QC records for testing performed from January 2026 through June 2026 identified two days of patient testing when QC was outside the limits of acceptability as follows; (a) 06/01/2026 - tHb Yellow was 6.9 (b) 04/23/2026 - tHb Yellow was 7.6 (3) There was no evidence corrective action had been taken for patients tested, when QC results were unacceptable. (4) On 07/21/2026 at 11:35 am technical consultant #1 confirmed QC was unacceptable for two of 62 days of patient testing, with no corrective action taken for patients tested. II. External Liquid QC (1) On 07/21/2026 at 11:35 am, technical consultant #1 stated the following: (a) tHB and %O2Hb (total hemoglobin and percent oxyhemoglobin) testing was performed using the Avoximeter analyzer; (b) Two levels of External QC were performed weekly (level 1 and level 3); (c) The range of acceptability for level 3 %O2Hb was 53.5 - 62.1; (d) The range of acceptability for level 3 tHb was 17.1 - 18.7. (2) A review of QC records identified the following QC failures; (a) On 04/06/2026 Level 3 tHb was 15.9; (b) On 05/26/2026 Level 3 tHb was 18.8; (c) On 06/08/2026 Level 3 %O2Hb was 52.9. (3) There was no evidence corrective action had been taken for the following patients, when QC results were unacceptable; (a) Patient #287018 tested on 05/26/2026 at 10:30 am; (b) Patient #85546 tested on 05/26/2026 at 08:30 am; (c) Patient #257425 tested on 06/11/2026 at 09:00 am; (d) Patient #255202 tested on 06/10/2026 at 07:03 am; (e) Patient #364330 tested on 06/08/2026 at 01:00 pm. (4) On 07/21/2026 at 11:35 am, technical consultant #1 confirmed 1 level of QC was unacceptable during those weeks, with no corrective action taken for patients tested.

D6053

TECHNICAL CONSULTANT RESPONSIBILITIES
CFR(s): 493.1413(b)(9)

(b)(9) Evaluating and documenting the performance of individuals responsible for moderate complexity testing at least semiannually during the first year the individual tests patient specimens.

This STANDARD is not met as evidenced by:

Based on a review of records and interview with the Laboratory Manager, Quality Manager and Lead Technologist, the laboratory failed to ensure competency evaluations for moderate complexity testing had been performed at least two times (semi-annually) during the first year of testing for two of two testing persons.

Findings include: (1) On 07/20/2026 at 10:50 am, the Laboratory Manager and the Lead Technologist stated the following: (a) Blood gas (pH, PCO₂, PO₂), Sodium (Na), Potassium (K,) Chloride (Cl), CO₂, BUN, Creatinine, Ionized Calcium, Glucose, Hemoglobin, and Hematocrit testing were performed using the Siemens EPOC analyzers (SN# 28949 and SN# 35059) and BGEM test cards; (b) Fractional Oxygen Saturation, Oxygen Content, and Total Hemoglobin testing were performed using the AVOXimeter 1000E analyzer; (c) Activated Clotting Time (ACT) testing was performed using the Hemochron Signature Elite analyzer and Hemochron ACT-LR test cuvette. (2) A review of personnel records for two testing persons performing moderate complexity testing from January 2025 through the current date identified no evidence semi-annual competency evaluations had been performed for two of two testing persons as follows: (a) Testing person #10: (i) First semi-annual competency evaluation for the AVOXimeter and Hemochron test systems was completed on 07/30 /2024. There was no evidence that the second semi-annual competency had been performed. (b) Testing Person #11: (i) The initial training for the EPOC test system was completed on 11/25/2024 and the first semi-annual competency evaluation was completed on 05/31/2025. There was no evidence that the second semi-annual competency evaluation had been performed. (3) The records were reviewed with the Laboratory Manager, Quality Manager and Lead Technologist, who stated on 07/20 /2026 at 01:50 pm, the second semi-annual competency evaluations had not been documented as performed as stated above.

D6054

TECHNICAL CONSULTANT RESPONSIBILITIES
CFR(s): 493.1413(b)(9)

(b)(9) Thereafter, evaluations must be performed at least annually

This STANDARD is not met as evidenced by:
Based on a review of records and interview with the Laboratory Manager, Quality Manager and Lead Technologist, the Technical Consultant failed to ensure personnel performing moderate complexity testing had been evaluated at least annually for one of three testing persons during the review period of January 2025 through the current date. Findings include: (1) On 07/20/2026 at 10:50am, the Laboratory Manager and the Lead Technologist stated the following: (a) Blood gas (pH, pCO₂, pO₂), Sodium (Na), Potassium (K), Chloride (Cl), CO₂, BUN, Creatinine, Ionized Calcium, Glucose, Hemoglobin, and Hematocrit testing were performed using the Siemens EPOC analyzers (SN# 28949 and SN# 35059) and BGEM test cards. (2) A review of personnel records for three testing persons performing moderate complexity testing from January 2025 through the current date identified no evidence annual competency evaluations had been performed for one of three testing persons as follows: (a) Testing Person #10: (i) Annual competency was not performed prior to 01/25/2026 for the EPOC test system. (3) The records were reviewed with Laboratory Manager, Quality Manager and Lead Technologist, who stated on 07/20/2026 at 01:00 pm, the annual competency evaluation had not been documented as performed as stated above.