STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375568	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulsa Center for Rehabilitation and Healthcare	6202 East 61st Street Tulsa, OK 74136

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident diagnosed with diabetes mellitus, who was ordered a routine blood test to monitor blood sugar levels, received the test for 1 (#2) of 5 sampled residents reviewed for unnecessary medications.The DON stated 60 residents at the facility had diabetes and all had their A1C tested at least annually.Findings:A facility policy titled Laboratory Services and Reporting, dated 07/2025, read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law.A face sheet, dated 08/01/25, for Res #2 showed the resident had diagnosis of diabetes mellitus.A physician's medication order, dated 08/01/25, showed Res #2 was to be administered Lantus Solostar (a brand of insulin) 100 units/ml. The order showed Res #2 was to receive 5 units of the insulin in the morning and 27 units in the afternoon.A physician's lab order, dated 10/04/24, showed Res #2 was to have a blood sample collected for an A1C test that would show the resident's average blood sugar level over the previous 3 months. The order showed the A1C test was to be conducted every February, May, August, and November.On 08/21/25 at 10:20 a.m., the administrator was asked to provide Res #2's A1C test results. The administrator stated they had searched the resident's records and had not found A1C test results for 02/2025. They stated they had thought at the time the dialysis company had been collecting those labs, so they had not.On 08/21/25 at 1:07 p.m., the ADON was asked if the A1C test results for Res #2 had been collected and tested. The ADON stated they had found the A1C test results for each month except for 02/2025. The ADON stated they had spoken with the contracted dialysis company that month and they believed the dialysis staff were going to perform the A1C test. The ADON stated that was why they did not collect the blood sample for testing. They stated in the end, Res #2's A1C was not collected as ordered for February 2025. The ADON stated the residents A1C was not tested again until May 2025.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview the facility failed to ensure medications were secure for 1 of 3 carts on the Southeast Hall. The DON identified 108 residents resided in the facility. Findings:On 08/20/25 at 10:47 a.m., a green capsule in a plastic medication cup was observed sitting on top of the medication cart unattended on the Southeast Hallway. A Policy dated 04/2018, titled Medication Storage In The Facility, read in part, The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 08/20/25 at 10:54 a.m., LPN # 2 stated they had left the medication on top of the medication cart. LPN # 2 stated they had intended to administer it to a resident but forgot. They stated leaving the medication unattended on the cart could result in the wrong resident taking the medication and could cause a medication error. They stated it should not have been left out on top of the cart and should have been secured inside the cart.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure staff were compliant with Infection prevention protocols during the provision of tracheostomy care for 1 (#5) of 5 residents reviewed for infection control procedures. The administrator identified 3 residents with a tracheostomy resided in the facility. On 08/20/25 at 12:48 p.m., LPN #1 was observed to provide tracheostomy care for Res #5. After starting care, LPN #1 discovered supplies needed were not available in the room, LPN #1 removed their gloves and gown and left the room. On 08/20/25 at 1:15 p.m., LPN #1 returned to the room with supplies and donned a gown and gloves in the room. LPN #1was not observed to sanitize their hands. LPN #1 then opened a pair of sterile gloves, removed the gloves they had on and donned sterile gloves. LPN #1 was not observed to sanitize their hands between glove changes. LPN #1 then opened supplies, opened an alcohol wipe and wiped off inner cannula with the alcohol wipe. LPN #1 cleaned the area around the tracheostomy site and placed the inner cannula. LPN #1 was not observed to change gloves between cleaning the site and placing the inner cannula. While wearing the same gloves, LPN #1 removed the old collar, cleaned the area around the site, opened a new collar, removed a pen from a pocket of their uniform, and labeled the collar. LPN #1 then placed the new collar, gathered up the trash and left the room. A physician order for Res #5, dated 01/30/25, showed enhanced barrier precautions were required related to tracheostomy care. A Hand Hygiene policy dated June 2025 showed a table for when hand sanitizing should occur. The table included:1. Before applying and after removing personal protective equipment (PPE), including gloves. 2. Before and after handling clean or soiled dressings. 3. After handling items potentially contaminated with blood, bodily fluids, secretions. On 08/21/25 at 2:44 p.m., the DON stated hand washing or sanitizing should occur before starting a procedure, between glove changes, and when the procedure was over.