Curtis Boyd M.D., P.C.

522 LOMAS BOULEVARD NE ALBUQUERQUE, NEW MEXICO 87102



December 12th, 2017

To Whom It May Concern,

Based on the report from the 12/6/17 CLIA site survey performed at our clinic, a box containing expired Alere hCG pregnancy testing cassettes was discovered to be in use. All expired cassettes were disposed of immediately that same day. Twelve of those cassettes were used in patient care. All twelve patients were accounted for. Of the twelve, five were "positive" and seven were "negative." Among the "positive" tests:

- Two patients received abortion services. Their pregnancles were confirmed using ultrasound.
- One patient was referred to the UNM Center for Reproductive Health to rule out the possibility
 of an ectopic pregnancy. Services included a repeat pregnancy test and subsequent treatment
 for an ectopic pregnancy.

The remaining nine patients were a mix of "positive" and "negative" results. These were "walk-in" patients who only received pregnancy testing at our clinic. At that time it had been the clinic policy to obtain the patient's name and date of birth for this service. For that reason, any attempts to notify them were not possible.

Several changes were made to correct this:

- The lab log was updated on 12/12/18 to include a space for entering lot numbers and expiration
 cates for pregnancy testing cassettes. This is performed daily whenever pregnancy testing is
 offered. It is entered by any testing personnel. The Lab Supervisor performs a daily review of the
 lab log, ensuring this information has been recorded in the log. The Lab Supervisor writes down
 his initials and the date performed at the bottom of the log.
- Pregnancy testing documentation has been updated to include a space for entering a patient's
 contact information, including their phone number and address. If there ever is a subsequent
 problem with pregnancy testing cassettes, this record can now be used to notify them.

Daniel Hicks, RN is responsible for these corrections. Copies of both the Lab Log and Request for Pregnancy Testing forms have been included with this letter for your review.

Thank you for your help with this matter.

Steve Thompson
Nursing and Lab Supervisor

A. BUILE B. WING	TIPLE CONSTRUCTION ING	COI	TE SURVEY MPLFTED	
B. WING		COMPLETED		
		12	/06/2017	
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	disposed of. The lab log was upon 12/12/17 by the RN to include a daily recording of lot numbers an expiration dates of pregnancy test cassettes and hemoglobin micros. The Lab Supervisor will review the daily and initial and date the log universe.	d st cuvettes e log		
	Information regarding expired pre	gnancy		
1200	TITLE	7/25	76) DATE	
	D 0	ALBUQUERQUE, NM 87102 D PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHE APPRIL CROSS-REFERENCE) 10 THE APPRIL DEFICIENCY) D D D D D D D D D	All expired tests were immediately disposed of. The lab log was updated on 12/12/17 by the RN to include a daily recording of lot numbers and expiration dates of pregnancy test cassettes and hemoglobin microcuvettes. The Lab Supervisor will review the log daily and initial and date the log upon review. (Please see attached letter for additional information regarding expired in SNULL SNU	

FORM CMS-2567(02-99) Pravious Versions Obsolete

Facility (D: 7050-57-04

If continuation sheet Page 1 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/09/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ COMPLETED 32D0534781 B. WING NAME OF PROVIDER OR SUPPLIER 12/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CURTIS BOYD MD PC 522 LOMAS BLVD NE ALBUQUERQUE, NM 87102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4)1D PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (A5) COMPLETION DATE TAG D 000 INITIAL COMMENTS D 000 The following deficiencies were cited during a recert fication survey completed on December 6, 2017 for the federal laboratory requirements of 42 CFR Part 493. D1001 CERTIFICATE OF WAIVER TESTS D1001 CFR(s): 493.15(e) Laboratories eligible for a certificate of waiver (1) Follow manufacturers' instructions for performing the test, and (2) Meet the requirements in subpart B. Certificate of Waiver, of this part. This STANDARD is not met as evidenced by: Based on observation, review of manufacturer instructions, patient test logs and interviews with laboratory staff, the laboratory failed to follow manufacturer instructions and discard expired pregnancy test kits when expired. This failed practice could result in the use of test kits that are not functioning correctly. Findings are: 1. Observation of laboratory supplies and review All expired tests were immediately of manufacturer labeling on 12/06/17 at 11:58 am disposed of. The lab log was updated on revealed the laboratory had not discarded 12/12/18 by the RN to include a expired pregnancy test kits and used them for daily recording of lot numbers and patient testing. expiration dates of pregnancy test a. Alere hCG (for urine pregnancy) lot cassettes and hemoglobin microcuvettes The Lab Supervisor will review the log HCG5060045 expiration date 04/2017 28 of 40 cassettes were remaining in the box. daily and initial and date the log upon There was no documentation of the open date or review. the received date on the box. (Please see attached letter for additional b. Alere hCG lot HCG5100027 expiration date information regarding explred pregnancy LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE tests) (XS) DATE 11-22-12-126-14

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 humes, the lindings stated above are disclosable 90 days following the date of survey whigher 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 of the safety of the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolute

Event ID, T3-IN11

Facility ID: 7050-57-04

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	was iden	tified	sting ov	er the 2 year period. TP #5	r.	COL	DIES Of this festing will be kent in	the !	
		nu a	YE/11 /U	testing person for 3 of 5 test 16, 3rd event 2016, and 1st		- II CL	IA manual in chronological ordo	rond	
	CAGIII SO	17. 1	1 P # 3 W	as identified on the testing		AAIII	serve as a schedule for this rot	ofion I	
	person fo	r the	2nd ev	ent of 2017.		165	sung personnel who have not us	done!	
	2 Roviel	u of i	h- 014	0.5		sch	ficiency testing will be the first of edule. Each TP will then completed	n this	
	Report F	orm:	ne CIVI:	S Form 209 Personnel ted by the laboratory,		test	ing as the test packets arrive ur	ete the	
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	personne			- y same may had s testing		oan	iples will arrive at the clinic in A	pril of	
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ND PLAN	OF CORRECTION	CIES	MEDICAID SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPLE CONSTRUCTION	FORM APPRO OMB NO. 0938-0
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i	fluctuations	and inte	rruptions in electrical current			Į.
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; 1	. Keview of	January	- June 2016 and January -		On 2/12/12 the Lat Di	i
_	Opticinibel 2	UH / HEIRI	lergior tempo to		On 2/13/18 the Lab Director detecting personnel	esignated
	nly 4 days p	HILL OF OO	cumenting the temperature		resulty personnel reconneits.	for
10.	··· y - uays p	week.			recording refrigerator tempera:	lures daily
2	Review of	the labor	totane malian to the second		whenever the clinic is open. The Supervisor pour months	ie Lab
th	e laborator	וופפל על	ratory policy indicated that nole blood samples from		Supervisor now monitors the temperature log on a world	
st	aff as contro	maleria	ils for Rh testing.	14	temperature log on a weekly be	asis to
	1	1	_		ensure this is performed, and in log.	nitials the
⅓ 3.	Observation	n of the	refrigerator contents on		-09.	T T
		eagents	were stored in the			
re	frigerator.	1	Signification of the			ų V
1	_		12/06/17 at 12:00 pm, the	10		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/09/2018 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 32D0534781 B. WING NAME OF PROVIDER OR SUPPLIER 12/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CURTIS BOYD MD PC 522 LOMAS BLVD NE ALBUQUERQUE, NM 87102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) ID TAG PREFIX (X5) COMPLETION TAG D5413 Continued From page 4 D5413 supervisor, (Testing Person #5) stated that the laboratory did not perform Rh testing on Mondays because nursing staff were not in the office. He also stated that the clinic was open to walk-in patients and urine pregnancy tests might be performed 15. The laboratory director did not comment on this finding during the exit interview on 12/06/17 at 1:00 pm. D5449 CONTROL PROCEDURES D5449 CFR(s): 493. 256(d)(3)(ii)(g) 510M Unless CMS Approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7) that provides equivalent quality testing, the laboratory must-At least once a day patient specimens are assayed or examined perform the following for--Each qualitative procedure, include a negative and positive control material; (g) The laboratory must document all control procedures performed. This STANDARD is not met as evidenced by: Based on the review of patient test records, quality control records, laboratory policies and interview with the laboratory director, the laboratory failed to perform and document a positive and negative control each day of patient testing. This failed practice could likely result in the reporting of erroneous patient results. The laboratory performed 11 Rh tests on 6/20/16 and

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Findings are: ORM CMS-2587(02-99) Previous Versions Obsolete

7 on 7/7/17

Event ID: T3HN11

Facility ID: 7050-57-04

If continuation sheet Page 5 of 12

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		15			Oi.		Ut the lab log is now performed	d by the	
	a. For 1	of 16 te	st days in	June 2016, the	1		Lab Supvisor on a daily basis.	This	
	iavolator	v raned	ID Derform	n and dogument the	21		review is performed to ensure	all patient	
	positive	and neg	ative cont sted (P#1-	rol for Rh testing. 1	1		information has been entered,	daily	
=	Panellis	were tes	iea (P#1-	-11).			controls have been performed	and	
1	b. a. Fo	1 of 16	toot dow	s in July 2017, the	1		perishable testing items do not their expiration dates.	exceed	
į	laborator	failed	o porform	and document the			aron expiration dates.		
1	positive a	nd neas	tive contr	rol for Rh testing. 7				i de la composición dela composición de la composición dela composición de la composición de la composición dela composición dela composición de la composición de la composición dela composición de la composición dela composición dela composición	
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D579	3 Continue	d Fro	om page 6	• 10 - 10 - 1	On 2/13/18 the Clinic Manage	r and Lah	
	This STA	NDA	RD is not met as evidenced by:	D579	Director implemented a tri-ani	nual lab	
	Daseuu	iii ine	review of nations toot recent	i	quality assurance review med	ting During	
	remperar	ure re	SCORD duality control recents	i i	unis meeting, a review of quali	ty control	
	Idroiato	y DON	CIES AND Interview with Inhance		topics, including adherence to	auglitu.	
	Judit, 1111	o lalle	U DESCREE COULD likely remark !-		control policies and accountat	ility,	
	ialiule (0)	ident.	ify failures in the laboratory and title actions.		will be discussed with relevant members and the Lab Supervi	staff	
	pendim	onec	tive actions.	£:	persons attending will sign an	sor. The	
	Findings	are:			form showing their participatio	attendence	
	, and	ui C.			review. The first meeting will b	n in the QA	
	1. The la	borate	ory failed to perform and		and will be repeated in August	9 4/9/18,	
	uocumen	(a bo	sitive and negative control each esting. See D5449	ia.	December,	1	
	1				On 2/15/18 a Tri-Annual review	/ was	
	the labora	torus	ory failed to monitor and documen	t	created by the RN. This will ha	i i	
	of the lah	rator	efrigerator temperature each day y was open. See D5413		performed in April, August, and	1	
	2 1	100			December of every year. Six of	narts and 🌯	
	3. Review	of la	boratory policies indicated that		men corresponding lab entrice	will bo	
	Andlin ast	sur and	CE SCIVILLES WOULD be need as the		inspected for accuracy and adh	erenceto	
	THOUGHT BY FRE	eeun	OS However there were		lab policies. The results will the	n be	
	uocumen	ation i	ID ADV of the 2016 2017		signed off by the Lab Supervisor Director. The first will be 4/9/18	r and Lab	
	mat audi d	ssea	THE TRILLIER TO CONFORM OF THE	9	form has been attached to this	. Inis	
	temperatu	res.	ilure to document refrigerator		to this	eview.	
1					On 2/15/18 an appual soules	1	
	4. The lab	orato	ry director did not comment on		On 2/15/18 an annual review was by the RN to begin in 12/18 and	as created	
10	mese muni	igs at	Unno the exit interview on		every subsequent December wi	the state of the s	
3004	12/06/17 a	11:40	pm.		entire lab testing team. Data will	in the	
-004	CFR(s): 49	3 140	DIRECTOR RESPONSIBILITIES	D6004	compiled from the previous year	De tri	
į.	0,11(3), 49	J. 140	7 (a)(b)		annual reviews and discussed in	Action	
1	The laboral	ory d	irector is responsible for the		plans will be created for the unco	mina	
	OACIGII ODE	ration	and administration of the		year to address any deficiencies	The	
	INDIBION	melilie	IDO the employment of		Lab Director will be responsible to	Or "	
7	herzouller M	vno ai	Competent to perform took		Conducting the meeting. The Lat		
1	PIOCEULIES.	. ann	record and report test seems.	1	Supervisor will be responsible to	. 9	
	promptly, ac	cural	te, and proficiently and for	1	overseeing any changes resulting		

DEPA	RTMENT (JF HI	EALTH	AND HUMAN SERVICES			Þ	PINTED	: 02/09/2018
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D6004	Continue	d Fr	pm pa	ge 7	Dec	104	On 2/13/18 the Clinic Manager and	Lab	
	assuring	com	pliance	e with the applicable	DOU	104	Director implemented a tri-annual I	ab 🕴	
	: regulatio	ns.			2		quality assurance review meeting	During	
	(a) The I	abora	atory d	irector, if qualified, may	-		this meeting, a review of quality co-	ntrol -	
	perform	he d	uties o	f the technical consultant,	*		topics, including adherence to qual	itv	
	clinical c	onsu	tant s	and testing personnel, or		- 1	control policies and accountability	,	1
	delegate	thes	e resp	onsibilities to personnel	2	- 4	will be discussed with relevant staff		
	meeting	the a	ualifica	ations of 493.1409, 493.1415,			members and the Lab Supervisor	The	=[
	and 493.	1421	respe	ectively			persons attending will sign an atten	dence	
	(b) If the	labo	atory	director reapportions		- 7	form showing their participation in t	ha OA	
	performa	nce e	of his c	or her responsibilities, he or			review. The first meeting will be 4/9	/40	
	she rema	ins n	esnone	sible for ensuring that all	ř.	1.0	and will be repeated in August and	/10,	
	duties an	e pro	perly r	erformed.			December.	İ	
	This STA	NDA	RD is	not met as evidenced by:			On 2/15/18 a Tri-Annual review was	- 1	
	Based o	n the	review	of laboratory policies,			created by the RN. This will be	3	
	proficienc	v tes	t reco	ds, personnel records, and		1	performed in April, August, and		10
	interview	with	labora	tory staff, the laboratory		1	December of averagest, and		
	director fa	iled	to prov	ride overall direction of the		43	December of every year. Six charts	and	
	laborator	v.	μ. σ.	in the store and the store of the		- 1	their corresponding lab entries will b	e i	
		-				- 0	inspected for accuracy and adheren	iceto	
	Findings	are:				90	lab policies. The results will then be	1	
						13	signed off by the Lab Supervisor an	d Lab	
	1. The la	borat	ory fail	led to perform and			Director. The first will be 4/9/19 This	0	4 15
	document	apd	sitive :	and negative control cook		I	form has been attached to this revie	W.	
	day or par	ient t	estina	Review of January June				!	
	ZU IO and	Janu	arv - S	eptember 2017 nations		C	On 2/15/18 an annual review was cr	eated	
	testing/qu	ality (control	Ous revealed 2 test days		- 0	by the RN to begin in 12/18 and ever	rv	
	when the	labor	atory f	ailed to perform a positive		S	subsequent December with the entir	a lab	
	and negat	ive d	ontrol.	,		te	esting team. Data will be compiled f	rom	
!		1				th	he previous years triannual reviews	and	1
	a. For 1 d	f 16	est da	ys in June 2016, the		d	iscussed. Action plans will be create	aliu	
i	laboratory	faile	d to pe	efform and document the		fo	or the upcoming year to address any	au :	
	positive at	na ne	gative	control for Rh testing 11		d	eficiencies. The Lab Director will be		-
	patients w	ere te	ested (P#1-11).		re	esponsible for conducting the meeting		
i	П.					Т	he Lab Supervisor will be responsib	ng.	
	p. a. For	1 of	6 test	days in July 2017, the		fc	proverseeing any change responsib	10	
	iaboratory	failed	to pe	fform and document the		th	proverseeing any changes resulting no annual meeting.	rrom	
1	positive an	ia nei	avite	control for Rh testing 7		111	o annual meetking.		
	patients w	ere te	sted (P#12-19). See D5449			. *** /-	E.	

DEPAR	RTMENT O	F HEALT	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTE	D: 02/09/2018 MAPPROVED
STALEMEN	T OF DEFICIE OF CORRECT	ANOTE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
			32D0534781	B. WING			
NAME OF	PROVIDER O	RSUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	12	/06/2017
CURTIS	BOYD MD	PC		52	22 LOMAS BLVD NE LBUQUERQUE, NM 87102		
(X4) ID PREFIX TAG	I ICAU	II DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CONTROL OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE	DDE	COMPLETION DATE
D6004	Continue	d From pa	age 8	D6004			
	i ine iabori	boratory t atory refrig See D5	ailed to monitor and document gerator temperature each day 413			# (
	monthly redocumenthat address control or temperati	surance and a second in a seco	atory policies indicated that ctivities would be part of the However, there was no ny of the 2016-2017 meetings failure to perform quality to document refrigerator	8000			
D6016	12/06/17	ings durin at 1:00 pm ORY DIR	ECTOR RESPONSIBILITIES	D6016		4000	
	overall operatory, personnel procedures promptly, assuring or regulations (e) The label (e) (4)(i) En	eration an including who are cos, and recorrate, compliance in corratory dissure that	tor is responsible for the d administration of the the employment of competent to perform test ord and report test results and proficiently and for with the applicable rector must—the proficiency testing	* V			
S	samples are of this part; This STANI	e tested a	is required under Subpart H	2			
F	orm 209 Fecords, an	Personnel d interviev	of 2016-2017 proficiency atory policies, the CMS Report Form, personnel ws with laboratory staff, the led to ensure that all testing	6		(1.00) (1.00) (1.00) (1.00)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/09/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 32D0534781 B. WING NAME OF PROVIDER OR SUPPLIER 12/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CURTIS BOYD MD PC 522 LOMAS BLVD NF ALBUQUERQUE, NM 87102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D6016 Continued From page 9 D6016 personnel participated in proficiency testing. Findings are: 1. Review of 2016-2017 proficiency testing On 2/13/18 the Lab Director instituted a records revealed only 2 of the laboratory's rotating schedule for testing personnel to current testing personnel had participated in perform proficency testing. The hard proficiency testing over the 2 year period. TP #5 copies of this testing will be kept in the was identified as the testing person for 3 of 5 test CLIA manual in chronological order and events, 2nd event 2016, 3rd event 2016, and 1st will serve as a schedule for this rotation. event 2017. TP #3 was identified as the testing Testing personnel who have not yet done person for the 2nd event of 2017. proficiency testing will be the first on this 2. Review of the CMS Form 209 Personnel schedule. Each TP will then complete the Report Form, completed by the laboratory, testing as the test packets arrive until all i indicated the laboratory currently had 5 testing have completed it. The next API testing personnel samples will arrive at the clinic in April of 2018. 3. Review of personnel files revealed that 5 of 5 testing personnel, TP #1 - TP #5 had been On 2/13/18 the Lab Director employed and trained to perform Rh testing prior implemented an annual skills evaluation to 2016. for all testing personnel. This includes a written exam and a performance exam. 4. Review of laboratory policies did not reveal The Lab Supervisor will oversee all skills any written policies concerning the testing evaluation, and the Lab Director will sign proficiency samples. off on the TP's certification. This will first be performed at the annual Lab QA 5. Testing person #5, the laboratory supervisor, meeting in December. Copies of these confirmed this finding during interview on forms have been included for review. 12/06/17. The laboratory director did not comment on this finding during the exit conference on 12/06/17 at 1:00 pm. D6030 LABORATORY DIRECTOR RESPONSIBILITIES D6030 CFR(s): 493.1407(e)(12)

ORM CMS-2567(02-99) Previous Versions Obsolete

The laboratory director is responsible for the overall operation and administration of the laboratory including the employment of

Event ID: T3HN11

Facility ID: 7050-57-04

If continuation sheet Page 10 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SL IDENTIFICATION		ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	//DER/SUPPLIER/CLIA ITRICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938- (X3) DATE SURVE COMPLETED	
	32D0534781		B. WING				
NAME OF	PROVIDER OR SU	PPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	12/	06/2017
CURTIS	BOYD MD PC		:	52	2 LOMAS BLVD NE BUQUERQUE, NM 87102		
(X4) ID PREFIX TAG	(EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
D6030	Continued Fr	rom page 10 no are competent to perform test	D60	30			
	procedures, promptly, acc	and record and report test results curate, and proficiently and for apliance with the applicable	ty	ė			
i i	regulations. (e) The labor	atory director must— ethat policies and procedures are				İ	
-	conduct prea	or monitoring individuals who nalytical, analytical, and	•11	:			
and management of the	competency i	phases of testing to assure that petent and maintain their or process specimens, perform test					
	needs for rem	nd report test results promptly and nd whenever necessary, identify nedial training or continuing		TE STE		!	
	This STANDA Based on the	mprove skills; RD is not met as evidenced by: review of proficiency testing					
1	records, perso interview with laboratory dire	onnel records, laboratory and the laboratory director, the		ક	n 2/13/18 the Lab Director and Lab upervisor agreed to include compete	ncy	
	of testing pers	ned for monitoring the competency connel. This failed practice could failure to identify training needs of mel.		ar de	view as part of the testing staffs tri- nnual meeting. A staff member esignated by the Lab Supervisor will emonstrate to the testing personnel i		
1	Findings are:			ble	nd hgb testing technique on stored good. The TP's performance will terward be discussed with the lab	n	
16	aporatory dire	cersonnel records revealed the ctor/technical consultant had not competency evaluations for 5 of pnel (TP #1- TP #5) hired prior to		te:	sting team. The person performing to sting will rotate based on the Lab spervisor's designation. The peyt	:	
1	ne last survey	on 12/14/2015.		SC	heduled competency evaluation will ld on 4/9/18.	be	
0	irector and co	tency documents had been signed by the previous laboratory histed of a checklist and no umentation of how the evaluations		100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON		RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		32D0534781	B. WING		40/00/00
	PROVIDER OR SUPPLIE	ER	52	REET ADDRESS, CITY, STATE, ZIP CODE 22 LOMAS BLVD NE LBUQUERQUE, NM 87102	12/06/2017
(X4) ID PREFIX TAG	I (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMBLETION
D6030	Continued From were performed.	page 11	D6030		
	evaluations was in Dates" but the inc	ation of current competency under the section "Review dividual checklist items were not urrent laboratory director for the ations.	F		
A manager of managers of	that only 2 (TP #3 testing personnel testing since 2015	iciency test records revealed and TP #5) of the current 5 had participated in proficiency 5 so proficiency testing could ed as part of the evaluation of competency.	į		
	that there was no	laboratory's policies revealed defined policy on how to betency of testing personnel.			
	4. The laboratory this finding during 12/06/17 at 1:00 p	director did not comment on the exit conference on m.	*		
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-			2		**
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