Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 04D2013619	(X3) Date Survey Completed 11/21/2024
Name of Provider or Supplier Northeast Arkansas Pain Medicine, Llc	**Street Address, City, State** 505 E Matthews Ave, Suite 103, Jonesboro, AR	

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
D5783	CORRECTIVE ACTIONS CFR(s): 493.1282(b)(2) (b) The laboratory must document all corrective actions taken, including actions taken when any of the following occur: (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: Review of the manufacturer's user manual for the Siemens Viva-E instrument, quality control (QC) results for October 2024, corrective action documentation, patient results, and interview determined that patient results were not evaluated to the last successful QC performance when QC failed and corrective action made changes in the test system operation for one of one instances reviewed. Findings follow: A) Review of the manufacturer's user manual for the Siemens Viva-E instrument revealed " C flag (Control Limit Violation) prepare fresh control or reagent solution if necessary". B) Through a review of Oxycodone (Oxy) QC results for October 2024 it was determined that on 10/16/24 Oxycodone 100 negative control was recorded as "positive" at 08:03 a.m. before being recorded as negative at 08:15 a.m. C) Review of corrective action documentation for OXY testing on that date revealed corrective action "calibrate and rerun" which indicated a change in the testing system. D) Review of patient results revealed that one OXY test was performed and reported on 10/15/24 (patient identified as number 3014). F) In an interview on 11/21/24 at 03:45 p.m., the laboratory staff members (# 2 and # 3 on the CMS 209 form) confirmed that the OXY result reported on 10/15/24 had not been evaluated.