

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 05D2113231	(X3) Date Survey Completed 09/23/2026
Name of Provider or Supplier Scpmg Central Medical Offices	Street Address, City, State 3733 San Dimas St, Bakersfield, CA	
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
D3011	FACILITIES CFR(s): 493.1101(d) Safety procedures must be established, accessible, and observed to ensure protection from physical, chemical, biochemical, and electrical hazards, and biohazardous materials. This STANDARD is not met as evidenced by: Based on the surveyors' observations during the laboratory tour, lack of a laboratory safety plan based on a risk assessment, and interviews with the administrative personnel (AP); the laboratory failed to have and follow a laboratory director-written and approved laboratory safety procedures to ensure protection from physical, chemical, biochemical, and biohazardous materials. The findings included: 1. The laboratory failed to have a written safety plan and procedures based on the laboratory's risk assessment to provide protection from physical, chemical, biochemical, and biohazardous materials as needed. 2. Surveyors observed the following during the laboratory tour: a. There was no evacuation route posted at the laboratory. b. There were no biological or chemical spill kits available in the testing area. c. There was no decontamination log dedicated to the testing area. 3. AP confirmed by interview on September 23, 2026, at approximately 4:00 p.m. that the laboratory did not have a laboratory director-written, approved, signed, and dated safety plan based on a risk assessment and lacked safety items as stated in 2. 4. The safety of laboratory testing personnel could not be assured at this time. 5. The annual testing declaration form signed and dated by the laboratory director submitted at the time of the survey stated 1,010 tests were processed and reported during the time when safety concern for all testing personnel could not be assured.
D5217	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1)

	At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part. This STANDARD is not met as evidenced by: Based on the lack of annual peer review documentation, three (3) randomly selected patient records, and interviews with the administrative personnel (AP), the laboratory failed at least twice annually to verify the accuracy of any test or procedure it performs. The findings included: 1. The laboratory began patient testing on January 5th, 2026, but failed to perform at least one peer review for the last nine months that patient diagnosis had taken place. 2. All three (3) randomly selected patient records were from the year 2026, and accuracy of the test cannot be verified at this time. 3. The AP confirmed by interview on September 23, 2026, at approximately 3:15 p.m. that the laboratory failed to conduct at least one peer review covering the testing and diagnosing period from January to September 2026. 4. The laboratory director reported in form CMS-116 on the day of the survey that the laboratory processed and reported 610 histopathology tests annually, for which at least once for the year 2026 peer review was not performed. The laboratory must at least twice annually, verify the accuracy of any test or procedure it performs.
D5291	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and, when indicated, correct problems identified in the general laboratory systems requirements specified at 493.1231 through 493.1236. This STANDARD is not met as evidenced by: Based on the surveyors' review of the laboratory's policies & procedures, three (6) randomly selected patients' test records, and interviews with the administrative personnel (AP); the laboratory failed to establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and, when indicated, correct problems identified in the general laboratory systems requirements. The findings include: 1. The laboratory failed to present a complete quality assurance plan for the current survey year, as evidenced by: a. The laboratory failed to present a comprehensive quality assurance plan that has been reviewed and approved by the current laboratory director. b. The laboratory failed to present a corrective action procedure and proof of any historical corrective action records. c. The laboratory failed to present a complete retention policy. Their current retention policy only includes the storage of slides but does not address a retention period for patient test results, standard operating procedures (SOPs), quality control logs and preventive maintenance. d. The laboratory failed to present complete SOPs for KOH (Mycology) and <i>Sarcoptes scabiei</i> (parasitology). 2. The AP confirmed on September 23, 2026, at approximately 3:45 p.m., that the laboratory did not have complete established policies and procedures as stated above in 1. 3. The laboratory's testing declaration form signed by the laboratory director September 9, 2026, stated that the laboratory performed approximately 1,010 tests annually for which their quality of testing cannot be assured due to the gaps in establishing and following the laboratory's SOPs and policies.
D5407	PROCEDURE MANUAL

	CFR(s): 493.1251(d) (d) Procedures and changes in procedures must be approved, signed, and dated by the current laboratory director before use. This STANDARD is not met as evidenced by: Based on the surveyors' review of the laboratory's policies and procedures, interviews with the administrative personnel (AP), and the three (3) randomly selected patient test records, the laboratory failed to have the laboratory director's signature and date of approval on all their policies and procedures. The findings included: 1. All the policies and standard operating procedures (SOPs) reviewed did not contain laboratory director's signature and date of approval. 2. The AP confirmed by interview on September 23, 2026, at the time of the survey that none of the procedures presented have been signed, approved and dated by the laboratory director. 3. The laboratory testing volume submitted at the time of the survey stated 1,010 tests annually were reported, during which time the laboratory director failed to approve, sign and date policies and SOPs.
D6082	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(1) (e) The laboratory director must-- (e)(1) Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing; This STANDARD is not met as evidenced by: Based on the surveyors' direct observation during the laboratory tour, review of policies and procedures, three (3) randomly selected patient test records, and interviews with the administrative personnel; the laboratory director is herein cited due to failure to manage that several aspects of the preanalytic and analytic phases of the laboratory testing were monitored. The findings include D3011, D5217, D5291, and D5407.
D6084	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(2) provide a safe environment in which employees are protected from physical, chemical, and biological hazards; This STANDARD is not met as evidenced by: Based on the surveyors' findings during the tour and lack of safety policies and procedures, the laboratory director is herein cited for the deficient practice in failure to provide an overall administration of the laboratory to ensure a safe environment in which personnel are protected from physical, chemical, biochemical, electrical hazards, and biohazardous materials. See D3011.