Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 09D2006294	**(X3) Date Survey Completed** 08/17/2018
Name of Provider or Supplier George Washington University Medical Faculty	**Street Address, City, State** 2300 M Street Nw Suite 210, Washington, DC	
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**
D5891	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(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 postanalytic systems specified in 493.1291. This STANDARD is not met as evidenced by: Based on the review of records (electronic medical records and the laboratory's test reporting forms) and confirmation by staff interview conducted on August 17, 2018, at approximately 4:00 PM, the laboratory's quality assessment plan for post analytic phase of testing failed to identify errors in entering Prostate Specific Antigen (PSA) results in patients' Electronic Medical Records (EMRs). Four (4) of the twelve (12) records randomly selected for review revealed errors (Accession #3 dated 4/2/2018; Accession #1 dated 4/4/2018; Accession #2 dated 4/17/2018; and Accession #8 dated 4/3/2018). The findings included: 1. Review of PSA test result reporting form for Accession #3 dated 4/2/2018 revealed that the specimen was collected on 4/2/2018 at 10:19 AM. The result was reported on the same day at 1:21 PM. However, review of the PSA result in the patient's EMR revealed that the result was reported on 1/13/2017 at 12:00 AM. Further review of the EMR revealed that the staff used the patient's 1/13 /2017 visit to document the PSA result instead of the 4/2/2018 visit. In addition, the reference range was not included with the PSA result reported in the patient's EMR. 2. Review of PSA test result reporting form for Accession #1 dated 4/4/2018 revealed that the specimen was collected on 4/4/2018 at 10:36 AM. The result was reported on the same day at 10:51 AM. The staff documented the PSA result with a "D" flag in the patient's EMR. According to interview with a supervisory staff, the "D" flag is not a flag it was a typographical error. The flag should have been "H" to indicate the abnormally high PSA result. 3. Review of PSA test result reporting form for Accession #2 dated 4/17/2018 revealed that the specimen was collected on 4/17/2018 at 9:37 AM. The result was reported on the same day at 9:52 AM. The PSA result

	documented in the patient's EMR lacked units of measurement. 4. Review of PSA test result reporting form for Accession #8 dated 4/3/2018 revealed that the specimen was collected on 4/17/2018 at 9:37 AM. The result was reported on the same day at 11:44 AM. The PSA result documented in the patient's EMR lacked the "H" flag to indicate the abnormally high PSA result. 5. Further interview with a supervisory staff confirmed the aforementioned errors and the lack of documentation to provide evidence that the errors were identified and corrected by the laboratory's post-analytic quality assessment process.