

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 12D0879051	(X3) Date Survey Completed 06/26/2026
Name of Provider or Supplier Diagnostic Laboratory Services - Kapahulu	Street Address, City, State 1029 Kapahulu Ave Ste 304, Honolulu, HI	
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
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: The surveyor's review of laboratory quality management procedures, the lack of documentation, and interview with the general supervisor (GS#3) revealed the laboratory failed to follow to monitor and assess 5 of 5 of its quality performance indicators during 2025 and 2026. The findings include: 1. The laboratory Satellite Quality Plan Section 4. Quality Monitors, Performance Indicators and Quality Assurance procedure states "4.1 Quality indicators are monitored by the laboratory which may include measures for pre-analytical, analytical, and post-analytical processes that affect quality service and patient safety". The laboratory Satellite Performance Indicator Operational Definitions lists five quality performance indicators: Patient Survey, Client Survey, Hand Hygiene, Test in Question (TIQ)-Accessioning Accuracy, and TIQ-Phlebotomy Accuracy. No documentation was presented for review to indicate the laboratory monitored these performance indicators to ensure established targets and reporting requirements were met. 2. GS#3 interviewed on 6/26/2026 at 10:00 AM stated collected monthly and biannual laboratory performance indicator data was combined and averaged with non-technical Patient Service Centers on Oahu and neighbor islands, and with 3 of 4 other neighbor island technical sites. GS#3 confirmed laboratory site specific performance indicator reports were not made available for laboratory review and evaluation. 3. The laboratory performed an annual volume of 193,320 routine chemistry tests and urine sediment examinations, and 16,476 hematology tests.

D6093

LABORATORY DIRECTOR RESPONSIBILITIES

CFR(s): 493.1445(e)(5)

(e)(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur;

This STANDARD is not met as evidenced by:

The surveyor's review of 2 of 2 laboratory quality management procedures, the lack of documentation, and interview with the general supervisor (GS#3) revealed the laboratory director failed to ensure its quality assessment program was maintained to ensure the quality of its routine chemistry, urine sediment, and hematology testing during 2025 and 2026. The findings include: 1. No documentation was presented for review to indicate the laboratory monitored 5 of 5 of its quality performance indicators to ensure established targets were met. 2. GS#3 interviewed on 6/26/2026 at 10:00 AM stated laboratory performance indicator reports contained combined and averaged data from non-technical and technical sites. GS#3 confirmed laboratory site specific data was not available for review and evaluation. 3. See Dtag D5291