Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	19D1094011	04/16/2026
Name of Provider or Supplier	**Street Address, City, State**	
North Caddo Medical Center	815 South Pine St, Vivian, LA	

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
D0000	A Recertification survey was performed at North Caddo Medical Center, CLIA ID 19D1094011, on April 13, 2026 through April 16, 2026. The laboratory was found in compliance with 42 CFR 493 Requirements for Laboratories; however, standard level deficiencies were cited.
D2009	TESTING OF PROFICIENCY TESTING SAMPLES CFR(s): 493.801(b)(1) (b)(1) The individual testing or examining the samples and the laboratory director must attest to the routine integration of the samples into the patient workload using the laboratory's routine methods. This STANDARD is not met as evidenced by: Based on review of the laboratory's proficiency testing records and interview with personnel, the laboratory failed to ensure the Laboratory Director signed the attestation statement form for one (1) of five (5) proficiency testing (PT) events reviewed from 2024, 2025 and 2026. Findings: 1. Review of the laboratory's American Proficiency Institute (API) proficiency testing records from 2024, 2025, and 2026 revealed the Laboratory Director did not sign the attestation statement form for one (1) of five (5) following proficiency testing events: a) 2025 Chemistry Core 2nd event 2. In interview on April 13, 2026 at 3:20 pm, Testing Personnel 1 confirmed the Laboratory Director did not sign the attestation for the identified PT event.
D5439	CALIBRATION AND CALIBRATION VERIFICATION CFR(s): 493.1255(b) (b)(1) Following the manufacturer's calibration verification instructions; (b)(2) Using the criteria verified or established by the laboratory under 493.1253(b)(3)-- (b)(2)(i) Including the number, type, and concentration of the materials, as well as acceptable limits for calibration verification; and (b)(2)(ii) Including at least a minimal (or zero)

	value, a mid-point value, and a maximum value near the upper limit of the range to verify the laboratory's reportable range of test results for the test system; and (b)(3) At least once every 6 months and whenever any of the following occur: (b)(3)(i) A complete change of reagents for a procedure is introduced, unless the laboratory can demonstrate that changing reagent lot numbers does not affect the range used to report patient test results, and control values are not adversely affected by reagent lot number changes. (b)(3)(ii) There is major preventive maintenance or replacement of critical parts that may influence test performance. (b)(3)(iii) Control materials reflect an unusual trend or shift, or are outside of the laboratory's acceptable limits, and other means of assessing and correcting unacceptable control values fail to identify and correct the problem. (b)(3)(iv) The laboratory's established schedule for verifying the reportable range for patient test results requires more frequent calibration verification. This STANDARD is not met as evidenced by: Based on observation of surveyors, review of laboratory policy and calibration records as well as interview with personnel, the laboratory failed to perform calibration verification procedures at least every six (6) months for the Opti CCA - TS2 analyzer. Findings: 1. Direct observation by surveyors during the laboratory tour on April 16, 2026 at 10:00 am revealed the laboratory utilizes the Opti CCA -TS2 analyzer for Arterial Blood Gas testing. 2. Review of the laboratory's "Opti TS2 Analyzer/Arterial Blood Gases" policy revealed "Calibration Verification allows for the validation of the blood gas analyzer's ability to recover known values or various points within the reportable range of all parameters and is required every 6 months". 3. Review of the laboratory's calibration verification records from 2024 and 2025 revealed the laboratory did have documentation of calibration verification for the following dates: a) July 31, 2024 b) May 5, 2025 4. Further review of the laboratory's calibration records revealed the laboratory did not have documentation of calibration verification from January 2025. 5. In interview on April 14, 2026 at 12:24 pm, Testing Personnel 1 confirmed the laboratory did not have documentation of calibration verification for the identified month.
D6014	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(3)(iii) (e)(3)(iii) Laboratory personnel are performing the test methods as required for accurate and reliable results; This STANDARD is not met as evidenced by: Based on observation by surveyor, review of laboratory policy and records, and interview with personnel, the Laboratory Director failed to ensure the laboratory personnel performed test methods as required. Refer to D5439.
D6018	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(4)(iii) (e)(4)(iii) All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratorys performance and to identify any problems that require corrective action; and This STANDARD is not met as evidenced by:

	Based on review of laboratory proficiency testing records and interview with personnel, the Laboratory Director failed to ensure proficiency testing attestation statements were signed by the appropriate personnel. Refer to D2009.