Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	19D2221312	01/13/2026
Name of Provider or Supplier	**Street Address, City, State**	
West Jefferson Medical Center-Ridgelake Imaging	2121 Ridgelake Dr, 1st Floor, Metairie, 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 West Jefferson Medical Center Ridgelake Imaging, CLIA ID 19D2221312, on January 13, 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 test records and interview with personnel, the laboratory failed to ensure the Laboratory Director signed the attestation statement form for one (1) of six (6) proficiency testing (PT) events reviewed for Creatinine. Findings: 1. Review of the laboratory's College of American Pathologists (CAP) proficiency testing records for 2024 and 2025 revealed the Laboratory Director did not sign the attestation form for the 2025 AQ-C event. 2. In interview on January 13, 2026 at 9:35 am, the Laboratory Director confirmed she did not sign the attestation statement form for the identified PT event.
D5891	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(a) (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 review of the laboratory's policies, records, and interview with personnel, the laboratory failed to follow their established procedures for the laboratory information system (LIS) verification for two (2) of two (2) years reviewed. Findings: 1. Review of the laboratory's "LIS System Verification" policy revealed "Evaluation and verification of computer-performed calculations is required upon initial implementation and thereafter annually or when a system change is made that may affect the calculation of patient results. Once monthly, or at appropriate frequency, a random historical patient's POC creatine {sic} is obtained from Telcor QML and printed. Additionally, manual calculation is performed to ensure that the system's auto calculated results are accurate. Compare the online calculated eGFR to the eGFR result on the EPIC specimen report to ensure that they are in concordance." 2. Review of the laboratory's records revealed the laboratory did not perform the following LIS verification procedures: a) Annual LIS check for 2024 b) Monthly random historical patient creatinine review for 2024 and 2025 3. In interview of January 13, 2026 at 11: 03 am ,the Laboratory Director stated she performed the annual LIS system verification in December 2023, not 2024. The Laboratory Director further stated at 11: 15 am, that she did not perform the monthly historical patient creatinine report review for this location for 2024 and 2025.
D6016	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(4)(i) (e)(4)(i) The proficiency testing samples are tested as required under Subpart H of this part; This STANDARD is not met as evidenced by: Based on review of the laboratory's proficiency testing records and interview with personnel, the Laboratory Director failed to ensure proficiency testing samples are tested as required. Refer to D2009.
D6020	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(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: Based on review of the laboratory's policies, records, and interview with personnel, the Laboratory Director failed to ensure the established quality assessment program was followed to assure the quality of laboratory testing results. Refer to D5891.