

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 23D0683833	(X3) Date Survey Completed 09/04/2025
Name of Provider or Supplier Parkside Pediatric Clinic	Street Address, City, State 2100 Fourth Street, Jackson, MI	
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	<p>A recertification survey was performed on September 4, 2025 by the State of Michigan Licensing and Regulatory Affairs Department. The laboratory was found to be out of compliance with CLIA regulations (42 CFR Part 493, Laboratory Requirements) for the following condition-level deficiencies: 493.1215 Condition: Hematology. 493.1403 Condition: Laboratories performing moderate complexity testing; laboratory director. 493.1409 Condition: Laboratories performing moderate complexity technical consultant.</p>
D5024	<p>HEMATOLOGY CFR(s): 493.1215</p> <p>If the laboratory provides services in the specialty of Hematology, the laboratory must meet the requirements specified in 493.1230 through 493.1256, 493.1269, and 493.1281 through 493.1299.</p> <p>This CONDITION is not met as evidenced by:</p> <ul style="list-style-type: none"> . Based on record review and interviews, the laboratory failed to establish test procedures to include specimen labeling, a step-by-step procedure for performing Complete Blood Count (CBC) testing, CBC reportable ranges, and CBC critical values (refer to D5403), failed to perform and document daily maintenance for its Medonic M-series hematology analyzer (refer to D5429 A), failed to perform and document monthly maintenance for its Medonic M-series hematology analyzer (refer to D5429 B), failed to follow its control procedures to test three control materials each day of testing (refer to D5441), failed to perform corrective actions when the Medonic M-Series hematology analyzer indicated it had a "Measurement Statistics Warning" (refer to D5781), failed to perform corrective action for patients tested when controls failed (refer to D5783), failed to perform corrective action when room temperature fell outside the established range (refer to D5785), and failed to ensure positive patient identification by including the patient's name and identification number (refer to D5805).

D5403

PROCEDURE MANUAL

CFR(s): 493.1251(b)

(b) The procedure manual must include the following when applicable to the test procedure: (b)(1) Requirements for patient preparation; specimen collection, labeling, storage, preservation, transportation, processing, and referral; and criteria for specimen acceptability and rejection as described in 493.1242. (b)(2) Microscopic examination, including the detection of inadequately prepared slides. (b)(3) Step-by-step performance of the procedure, including test calculations and interpretation of results. (b)(4) Preparation of slides, solutions, calibrators, controls, reagents, stains, and other materials used in testing. (b)(5) Calibration and calibration verification procedures. (b)(6) The reportable range for test results for the test system as established or verified in 493.1253. (b)(7) Control procedures. (b)(8) Corrective action to take when calibration or control results fail to meet the laboratory's criteria for acceptability. (b)(9) Limitations in the test methodology, including interfering substances. (b)(10) Reference intervals (normal values). (b)(11) Imminently life-threatening test results, or panic or alert values. (b)(12) Pertinent literature references. (b)(13) The laboratory's system for entering results in the patient record and reporting patient results including, when appropriate, the protocol for reporting imminently life threatening results, or panic, or alert values. (b)(14) Description of the course of action to take if a test system becomes inoperable.

This STANDARD is not met as evidenced by:

. Based on record review and interview with testing personnel #1, the laboratory failed to establish test procedures to include specimen labeling, a step-by-step procedure for performing Complete Blood Count (CBC) testing, CBC reportable ranges, and CBC critical values for two (September 2023 to September 2024) of two years reviewed. Findings include: 1. A review of the laboratory's test procedures revealed a lack of Complete Blood Count (CBC) testing, step-by-step procedure for performing CBC reportable ranges, and CBC critical values. 2. An interview on 9/4/25 at 12:09 pm with testing personnel #1 confirmed the test procedure components listed above.

D5429

MAINTENANCE AND FUNCTION CHECKS

CFR(s): 493.1254(a)(1)

(a)(1) Maintenance as defined by the manufacturer and with at least the frequency specified by the manufacturer.

This STANDARD is not met as evidenced by:

. A. Based on record review and interview with testing personnel #1, the laboratory failed to perform and document daily maintenance for its Medonic M-series hematology analyzer for two (September 2023 to September 2025) of two years reviewed. Findings include: 1. A review of the laboratory's Medonic M-Series operator's manual revealed section eight, titled "Cleaning, Maintenance & Transport" stating, "The Daily Cleaning takes only a few minutes, the instructions are as follows: Remove possible traces of salt crystals or blood at the top of the aspiration and pre-dilute probes, probe rinse cup, and around top of sampling device probe inlet (if applicable) using a paper tissue with a disinfecting solution." 2. A review of the laboratory's procedure manual revealed a section stating, "Parkside Clinic lab uses a CDS M/Series Hematology Analyzer for the CBC's. The operator's manual is in the lab next to the CDS M/Series" and "It is the policy of this lab to perform maintenance

on the Medonic M series every 1 to 3 months following the Users Manual. And perform 6 month cleaning when performing the calibration [sic]." This did not mention performance of daily maintenance in accordance with manufacturer's instructions. 3. A review of the laboratory's maintenance records between September 2023 and September 2025 revealed a lack of documentation of daily maintenance performed. 4. An interview on 9/4/25 at 1:34 pm with testing personnel #1 confirmed daily maintenance was not performed and documented between September 2023 and September 2025. B. Based on record review and interview with testing personnel #1, the laboratory failed to perform and document monthly maintenance for its Medonic M-series hematology analyzer for five (November 2023, January 2024, June 2024, November 2024, and June 2025) of 24 months reviewed. Findings include: 1. A review of the laboratory's Medonic M-Series operator's manual revealed section eight, titled "Cleaning, Maintenance & Transport" stating, "Monthly Cleaning procedure takes approximately 10 minutes, instructions are as follows: Clean the aspiration probes using an alcohol wipe. Fill a cup with 10 ml 2% hypochlorite (Bottle #2 from Boule Cleaning Kit) and one cup with 18 ml diluent. (recommend use of dispense function for obtaining diluent see Section 5.6 Dispense Function). Aspirate the hypochlorite as pre-dilute sample, and then repeat. Run 2 blank samples by aspirating diluent as pre-diluted sample. Perform a background check, in pre-dilute mode, to verify all values are within range. See Section 5.3 for more details." 2. A review of the laboratory's procedure manual revealed a section stating, "Parkside Clinic lab uses a CDS M/Series Hematology Analyzer for the CBC's. The operator's manual is in the lab next to the CDS M/Series" and "It is the policy of this lab to perform maintenance on the Medonic M series every 1 to 3 months following the Users Manual. And perform 6 month cleaning when performing the calibration [sic]." 3. A review of the laboratory's maintenance records revealed a lack of documentation of monthly maintenance for the following months: a. November 2023 b. January 2024 c. June 2024 d. November 2024 e. June 2025 4. An interview on 9/4/25 at 1:34 pm with testing personnel #1 confirmed documentation of monthly maintenance was not present for the months listed above.

D5441

CONTROL PROCEDURES
CFR(s): 493.1256(a)(b)(c)(g)

(a) For each test system, the laboratory is responsible for having control procedures that monitor the accuracy and precision of the complete analytic process. (b) The laboratory must establish the number, type, and frequency of testing control materials using, if applicable, the performance specifications verified or established by the laboratory as specified in 493.1253(b)(3). (c) The control procedures must-- (c)(1) Detect immediate errors that occur due to test system failure, adverse environmental conditions, and operator performance. (c)(2) Monitor over time the accuracy and precision of test performance that may be influenced by changes in test system performance and environmental conditions, and variance in operator performance.

This STANDARD is not met as evidenced by:
 . Based on record review and interview with testing personnel #1, the laboratory failed to follow its control procedures to test three control materials each day of testing for three (11/3/23, 11/29/23, and 1/27/25) of 10 patient testing dates reviewed. Findings include: 1. A review of the laboratory's "Daily running of the laboratory" policy included a section stating, "Run controls (low, normal and high)." 2. A review of the laboratory's "Quality Control Program" policy revealed a section stating, "The type of control used is whole blood purchased from CDS. This control has pre-established,

known (assayed) ranges for our specific CDS/Series Hematology Analyzer. Each day of lab operation, the 3 controls (low, normal, high) will be run every day before patient tests are run." 3. A review of the laboratory's control data for 10 patient testing dates revealed the following dates the laboratory failed to perform three levels of controls: a. 11/3/23, levels two and three performed. b. 11/29/23, levels one and two performed. c. 1/27/25, levels two and three performed. 4. An interview on 9/2/25 at 2:36 pm with testing personnel #1 confirmed the laboratory had not performed three levels of control testing each date of patient testing for the dates listed above.

D5781

CORRECTIVE ACTIONS
CFR(s): 493.1282(b)(1)

(b) The laboratory must document all corrective actions taken, including actions taken when any of the following occur: (b)(1) Test systems do not meet the laboratory's verified or established performance specifications, as determined in 493.1253(b), which include but are not limited to-- (b)(1)(i) Equipment or methodologies that perform outside of established operating parameters or performance specifications; (b)(1)(ii) Patient test values that are outside of the laboratory's reportable range of test results for the test system; and (b)(1)(iii) When the laboratory determines that the reference intervals (normal values) for a test procedure are inappropriate for the laboratory's patient population.

This STANDARD is not met as evidenced by:
. Based on record review and interview with testing personnel #1, the laboratory failed to perform corrective actions when the Medonic M-Series hematology analyzer indicated it had a "Measurement Statistics Warning" for one (Patient #4) of 10 patient test reports reviewed. Findings include: 1. A review of 10 patient test reports revealed Patient #4 received Complete Blood Count (CBC) testing on 12/13/24. The test report included the code "SE" next to the leukocyte count. 2. A review of the laboratory's Medonic M-Series operator's manual revealed a section titled "9.2 System Information Messages" stating: "Indicator: SE Message: Measurement Statistic Warning; re-analyze Description: The rate of cell pulses per time unit varies too much. Possible reasons might be clogging, air bubbles, electrical disturbances or difficult to lyse cells. Note: Filtered away cells might raise the SE flag, so it might be possible to see them in the histograms or the result parameters. Action: Re-analyze sample." 3. An interview on 9/4/25 at 2:36 pm with testing personnel #1 confirmed corrective actions were not performed for Patient #4.

D5783

CORRECTIVE ACTIONS
CFR(s): 493.1282(b)(2)

(b)(2) Results of control or calibration materials, or both, fail to meet the laboratory's established criteria for acceptability. All patient test results obtained in the unacceptable test run and since the last acceptable test run must be evaluated to determine if patient test results have been adversely affected. The laboratory must take the corrective action necessary to ensure the reporting of accurate and reliable patient test results.

This STANDARD is not met as evidenced by:
. Based on record review and interview with testing personnel #1, the laboratory failed to perform corrective action for patients tested when controls failed for four total

patients receiving Complete Blood Count (CBC) testing on 11/29/23. Findings include: 1. A review of the laboratory's "Director for running controls" revealed a section stating, "2 out of 3 controls must fall within the limits given by manufacturer. If yes then patient tests can be run. If 2 out of 3 controls are not within limits given by manufacturer, then no patient tests can be run and the lab director is to be notified. [sic]" 2. A review of the laboratory's control records for 11/29/23 revealed the following results for controls: a. Level 1, performed 11/29/23 at 10:11 am and 10:20 am passed for all analytes. b. Level 2, performed 11/29/23 at 10:12 am failed for Erythrocytes (RBC) with the result of 3.67 (range of 3.99 to 4.35), Hematocrit (HCT) with a result of 31.0 (range of 32.5 to 38.5), Mean Corpuscular Hemoglobin (MCH) with a result of 33.6 (range of 28.2 to 31.2), and Mean Corpuscular Hemoglobin Concentration (MCHC) with a result of 39.8 (range or 31.4 to 38.4). c. Level 2, performed 11/29/23 at 10:25 am failed for RBC on the low end with the result of 3.92 (range of 3.99 to 4.35) and Hemoglobin (HGB) on the low end with the result of 11.9 (range of 12.0 to 12.8). d. Level 2, performed 11/29/23 at 10:40 am failed for HGB with the result of 12.9 (range of 12.0 to 12.8). e. No results were present for Level 3. 3. A review of the laboratory's run data revealed four patients received testing on 11/29/23. 4. A review of the laboratory's "Quality Assessment Review" dated 12/20/23 for "Control Procedures" revealed the "Evaluation of Results" to be "passed". 5. A review of the laboratory's "Quality Assessment Review" dated 5/21/24 for "Corrective Actions" revealed a section stating, "Lab will record all errors & problems. For each significant problem, corrective actions will be implemented if possible & be documented. At a later time, review problem to determine the effectiveness of our correction action & take additional actions if needed. [sic]" Under the "Evaluation of Results" section had "passed" written. No documentation of corrective action was present. 6. An interview on 9/4/25 at 2:36 pm with testing personnel #1 confirmed control results did not meet laboratory and manufacturer requirements prior to reporting patients and confirmed corrective action for the four patients tested had not been performed.

D5785

CORRECTIVE ACTIONS
CFR(s): 493.1282(b)(3)

(b)(3) The criteria for proper storage of reagents and specimens, as specified under 493.1252(b), are not met.

This STANDARD is not met as evidenced by:
. Based on record review and interview with testing personnel #1, the laboratory failed to perform corrective action when room temperature fell outside the established range for two (1/18/24 and 2/20/25) of 10 patient testing dates reviewed. Findings include:
1. A review of the laboratory's "Operating Environment for Medonic" policy revealed the room temperature range to be "64 degrees to 90 degrees F" and had a section stating, "If temperature or humidity falls out of range, contact lab director. Adjust Thermostat and/or run a dehumidifier. Follow up by checking temperature/humidity every 30 minutes till in range. Write down temperature/humidity at bottom of monthly page. If not corrected contact lab director. [sic]" 2. A review of 10 patient testing dates revealed the following dates when room temperature was out of range and no documentation of corrective action on the monthly logs were present, as indicated in the policy: a. 1/18/24, 50 degrees F. b. 2/20/25, 59 degrees F. 3. A review of the patient run data revealed a total of six patients were tested on the two testing dates

listed above. 4. An interview on 9/4/25 at 12:14 pm with testing personnel #1 confirmed corrective action was not performed when the room temperature fell out of range for the testing dates listed above.

D5805

TEST REPORT

CFR(s): 493.1291(c)

(c) The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.

This STANDARD is not met as evidenced by:

. Based on record review and interview with testing personnel #1, the laboratory failed to ensure positive patient identification by including the patient's name and identification number for 9 (Patients 1, 3, 4, 5, 6, 7, 8, 9, and 10) of 10 patient test reports reviewed. Findings include: 1. A review of patient test reports revealed the following failed to include either the patient's name and identification number, or a unique patient identifier and identification number: a. Patient #1 with the test report dated 7/14/25 had four of six letters from their first name and three of seven letter from their last name. No identification number was present. b. Patient #3 with the test report dated 2/20/25 had three of six letters from their first name and the complete last name present. The identification number on the test report was 200 more and lacked one character than what was indicated on the test request. c. Patient #4 with the test report dated 12/13/24 had three of eight letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. d. Patient #5 with the test report dated 9/11/24 had three of the six letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. e. Patient #6 with the test report dated 6/5/24 had three of the five letters from their first name and the complete last name. No identification number was present. f. Patient #7 with the test report dated 4/11/24 had three of the five letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. g. Patient #8 with the test report dated 2/5/24 had two of the six letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. h. Patient #9 with the test report dated 11/17/23 had two of six letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. i. Patient #10 with the test report dated 10/31/23 had three of six letters from their first name and the complete last name. The identification number on the test report was missing the last character as compared to the number on the test request. 2. An interview on 9/4/25 at 12:13 pm with testing personnel #1 revealed the identification number on the reports is the account number and last character on the patient test requests is used to differentiate between siblings on the same family

	<p>account, making the identification number on the test reports not unique to the patient. Testing personnel #1 confirmed the laboratory uses truncated names on the test reports.</p>
<p>D6000</p>	<p>MODERATE COMPLEXITY LABORATORY DIRECTOR CFR(s): 493.1403</p> <p>The laboratory must have a director who meets the qualification requirements of 493.1405 of this subpart and provides overall management and direction in accordance with 493.1407 of this subpart.</p> <p>This CONDITION is not met as evidenced by: . Based on record review and interviews, the laboratory director failed to ensure a corrective action plan was followed when the laboratory received unacceptable proficiency testing results (refer to D6019), failed to ensure control procedures were maintained to test three control materials each day of testing (refer to D6020 A), failed to ensure corrective actions for patients were performed when controls failed (refer to D6020 B), failed to ensure corrective actions were performed when the Medonic M-Series hematology analyzer indicated it had a "Measurement Statistics Warning" (refer to D6024), failed to ensure positive patient identification by including the patient's name and identification number on test reports (refer to D6026), and failed to establish test procedures to include specimen labeling, a step-by-step procedure for performing Complete Blood Count (CBC) testing, CBC reportable ranges, and CBC critical values (refer to D6031).</p>
<p>D6019</p>	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(4)(iv)</p> <p>(e)(4)(iv) An approved corrective action plan is followed when any proficiency testing results are found to be unacceptable or unsatisfactory;</p> <p>This STANDARD is not met as evidenced by: . Based on record review and interview with testing personnel #1, the laboratory director failed to ensure a corrective action plan was followed when the laboratory received unacceptable proficiency testing results for four (2023 Event 3, 2024 Event 1, 2024 Event 3, and 2025 Event 1) of six events reviewed. Findings include: 1. A review of the laboratory's "Proficiency Testing" policy revealed a lack of process for the laboratory to address unacceptable proficiency testing results. 2. A review of the laboratory's American Proficiency Testing (API) proficiency testing records revealed the following events with unacceptable results and a lack of corrective action performed: a. 2023 Event 3 had unacceptable performance for Lymphocytes specimen HSY-13. b. 2024 Event 1 had unacceptable performance for Red Cell Count for specimen HSY-05. c. 2024 Event 3 had unacceptable performance for Lymphocytes for specimen HSY-14. d. 2025 Event 1 had unacceptable performance for Red Cell Count for specimen HSY-03. 3. An interview on 9/4/25 at 12:14 pm with testing personnel #1 confirmed corrective action was not completed for the proficiency testing events listed above.</p>
<p>D6020</p>	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(5)</p>

	<p>(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;</p> <p>This STANDARD is not met as evidenced by: . A. Based on record review and interview with testing personnel #1, the laboratory director failed to ensure control procedures were maintained to test three control materials each day of testing. Refer to D5441. B. Based on record review and interview with testing personnel #1, the laboratory director failed to ensure corrective actions for patients were performed when controls failed. Refer to D5783.</p>
D6024	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(7)</p> <p>(e)(7) Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratorys established performance specifications are identified, and that patient test results are reported only when the system is functioning properly;</p> <p>This STANDARD is not met as evidenced by: . Based on record review and interview with testing personnel #1, the laboratory director failed to ensure corrective actions were performed when the Medonic M-Series hematology analyzer indicated it had a "Measurement Statistics Warning". Refer to D5781.</p>
D6026	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(8)</p> <p>(e)(8) Ensure that reports of test results include pertinent information required for interpretation;</p> <p>This STANDARD is not met as evidenced by: . Based on record review and interview with testing personnel #1, the laboratory director failed to ensure positive patient identification by including the patient's name and identification number on test reports. Refer to D5805.</p>
D6031	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(13)</p> <p>(e)(13) Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process; and</p> <p>This STANDARD is not met as evidenced by: . Based on record review and interview with testing personnel #1, the laboratory director failed to establish test procedures to include specimen labeling, a step-by-step procedure for performing Complete Blood Count (CBC) testing, CBC reportable ranges, and CBC critical values. Refer to D5403.</p>
D6033	<p>TECHNICAL CONSULTANT-MODERATE COMPLEXITY</p>

CFR(s): 493.1409

The laboratory must have a technical consultant who meets the qualification requirements of 493.1411 of this subpart and provides technical oversight in accordance with 493.1413 of this subpart.

This CONDITION is not met as evidenced by:

. Based on record review and interviews, the technical consultant failed to perform direct observations of instrument maintenance and function check performance as part of testing personnel competency assessments (refer to D6050), failed to perform assessments of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples (refer to D6051), and failed to perform assessments of problem-solving skills as part of testing personnel competency assessments (refer to D6052).

D6050

TECHNICAL CONSULTANT RESPONSIBILITIES

CFR(s): 493.1413(b)(8)(iv)

(b)(8)(iv) Direct observation of performance of instrument maintenance and function checks;

This STANDARD is not met as evidenced by:

. Based on record review and interview with testing personnel #1, the technical consultant failed to perform direct observations of instrument maintenance and function check performance as part of testing personnel competency assessments for two (testing personnel #3 and #4) of four testing personnel listed on Form CMS-209. Findings include: 1. A review of testing personnel competency assessments revealed a lack of technical consultant documentation of direct observation of instrument maintenance and function check performance as part of testing personnel competency assessments for the following testing personnel: a. Testing personnel #3 for competency assessments completed 12/6/23 and 12/3/24. b. Testing personnel #4 for competency assessments completed 12/6/23 and 12/4/24. 2. An interview on 9/4/25 at 10:17 am with testing personnel #1 confirmed direct observations of instrument maintenance and function check performance as part of testing personnel competency assessments were not present for the testing personnel listed above.

D6051

TECHNICAL CONSULTANT RESPONSIBILITIES

CFR(s): 493.1413(b)(8)(v)

(b)(8)(v) Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and

This STANDARD is not met as evidenced by:

. Based on record review and interview with testing personnel #1, the technical consultant failed to perform assessments of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples for one (testing personnel #3) of four testing personnel listed on Form CMS-209. Findings include: 1. A review of testing personnel competency assessments revealed a lack of technical consultant documentation of assessments of test performance through testing previously analyzed specimens, internal blind testing

samples or external proficiency testing samples as part of testing personnel competency assessments for testing personnel #3 for the competency assessment completed 12/4/24. 2. An interview on 9/4/25 at 10:17 am with testing personnel #1 confirmed assessments of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples as part of testing personnel competency assessments were not present for testing personnel #3.

D6052

TECHNICAL CONSULTANT RESPONSIBILITIES
CFR(s): 493.1413(b)(8)(vi)

(b)(8)(vi) Assessment of problem-solving skills; and

This STANDARD is not met as evidenced by:
. Based on record review and interview with testing personnel #1, the technical consultant failed to perform assessments of problem-solving skills as part of testing personnel competency assessments for four (testing personnel #1-#4) of four testing personnel listed on Form CMS-209. Findings include: 1. A review of testing personnel competency assessments revealed a lack of technical consultant documentation of assessments of problem-solving skills as part of testing personnel competency assessments for the following testing personnel: a. Testing personnel #1 for competency assessments completed 12/6/23 and 12/4/24. b. Testing personnel #2 for competency assessments completed 12/6/23 and 12/3/24. c. Testing personnel #3 for competency assessments completed 12/6/23 and 12/3/24. d. Testing personnel #4 for competency assessments completed 12/6/23 and 12/4/24. 2. An interview on 9/4/25 at 10:17 am with testing personnel #1 confirmed assessments of problem-solving skills were not present for the testing personnel listed above.