

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 29D0539610	(X3) Date Survey Completed 06/17/2025
Name of Provider or Supplier Cancer Care Specialists	Street Address, City, State 5423 Reno Corporate Drive, Reno, NV	
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	This Statement of Deficiencies was created as a result of an on-site CLIA recertification survey conducted at your facility on June 17, 2025. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.
D2007	<p>TESTING OF PROFICIENCY TESTING SAMPLES CFR(s): 493.801(b)(1)</p> <p>(b)(1) The samples must be examined or tested with the laboratory's regular patient workload by personnel who routinely perform the testing in the laboratory, using the laboratory's routine methods.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the College of American Pathologists (CAP) proficiency testing (PT) attestations from August 2023 through May 2025, a review of the CMS 209 form, and an interview with the Technical Consultant, the laboratory failed to ensure that all testing personnel routinely performing patient testing were performing proficiency testing. Findings include: 1. A review of the PT attestations from CAP revealed that the proficiency testing was not rotated among the testing personnel routinely performing patient testing. 2. A review of the CMS 209 form revealed that testing personnel number one was performing all PT testing events for Hematology Automated Differential. 3. An interview with the Technical Consultant on June 17, 2025 at approximately 11:30 AM confirmed these findings and indicated that testing personnel two through eight perform hematology for patients. The laboratory performs approximately 167,928 hematology tests annually.</p>
D5215	<p>EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(b)(2)</p>

The laboratory must verify the accuracy of any analyte, specialty or subspecialty assigned a proficiency testing score that does not reflect laboratory test performance (that is, when the proficiency testing program does not obtain the agreement required for scoring as specified in subpart I of this part, or the laboratory receives a zero score for nonparticipation, or late return or results).

This STANDARD is not met as evidenced by:
Based on a review of the laboratory's policies and procedures, a review of the College of American Pathologists (CAP) proficiency testing (PT) documentation, and an interview with the Technical Consultant, the laboratory failed to ensure that the results that were non-graded by the proficiency testing agency were evaluated and documented. Findings include: 1. A review of the laboratory director approved policy titled "Quality Assessment", states that "Ungraded PT results (due to lack of consensus, nonparticipation, or late return of results) are self-graded by the laboratory, using the PT agency's report and summary sheets". 2. A review of CAP PT documentation of the second event of 2023 for Reticulocyte found that educational challenge was not evaluated. 3. A review of CAP PT documentation of the first event of 2024 for Blood Cell ID (BCP) found that educational challenge was not evaluated. 4. A review of CAP PT documentation of the second event of 2024 for BCP found that educational challenge was not evaluated. The laboratory performs approximately 167,928 hematology tests annually. This has been cited previously at a recertification survey performed on July 19, 2023.

D5221

EVALUATION OF PROFICIENCY TESTING PERFORMANCE
CFR(s): 493.1236(d)

All proficiency testing evaluation and verification activities must be documented.

This STANDARD is not met as evidenced by:
Based on a review of the laboratory's CAP PT evaluations for the Ligand and Reticulocyte PT events from August 2023 through May 2025, and an interview with the Technical Consultant, the laboratory failed to evaluate and document corrective action for the unacceptable PT results. Findings include: 1. A review of the CAP PT evaluations from August 2023 through May 2025 revealed that the second event of 2023 for Reticulocyte sample RT 4-04 was unacceptable. There was no documented investigation or corrective action. 2. A review of the CAP PT evaluations from August 2023 through May 2025 revealed that the results for "hCG, serum quant" were unacceptable for sample K-15 in the third Ligand PT event of 2023. There was no documented investigation or corrective action. 3. An interview with the Technical Consultant on June 17, 2025 at approximately 12:30 PM confirmed these findings. The laboratory performs approximately 979 general immunology and 167,928 hematology tests annually.

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:
Based on a review of the personnel competency records, the proficiency testing (PT) records, the Quality Assessment (QA) policy, and an an interview with the Technical Consultant, the laboratory failed to follow their written procedure to monitor, assess, and correct problems in the laboratory. Findings include: 1. A review of the personnel competency records revealed that two of eight testing personnel did not have documented semi-annual competency assessments for 2023 (Refer to D6053). 2. A review of the personnel competency records revealed that six of eight testing personnel did not have documented annual competency assessments for 2024 (Refer to D6054). 3. A review of the PT records found that the laboratory failed to review non-graded PT results for two PT events between August 2023 and December 2024 (Refer to D5215). 4. A review of the QA policy and checklist found that personnel competency and review of proficiency testing were checklist items. All items had been marked as complete between August 2023 and May 2025, but the review was inadequate to detect the errors in quality and correct them. 5. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 3:30 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

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:
Based on a review of the AU480 Analyzer maintenance logs, a review of the Access 2 System maintenance logs, a review of the Sysmex XN 2000 maintenance logs, and an interview with the Technical Consultant, the laboratory failed to ensure equipment maintenance was performed as required. Findings include: 1. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2024 one of four weekly maintenance was not performed. 2. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2024 two of two every other weekly maintenance was not performed. 3. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2024 the monthly maintenance was not performed. 4. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in September 2024 two of 16 daily maintenance was not performed. 5. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in September 2024 one of four weekly maintenance was not performed. 6. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in November 2024 one of four weekly maintenance was not performed. 7. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in December 2024 one of four weekly maintenance was not performed. 8. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in December 2024 one of two every other weekly maintenance was not performed. 9. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in December 2024 the monthly maintenance was not performed. 10. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed

that in January 2025 one of four weekly maintenance was not performed. 11. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2025 four of 16 daily maintenance was not performed. 12. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2025 two of four weekly maintenance was not performed. 13. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that in March 2025 one of two every other weekly maintenance was not performed. 14. A review of the AU480 Analyzer maintenance logs from August 2023 through May 2025 revealed that January 2024 was the only month when quarterly maintenance was performed for 2024. 15. A review of the Access 2 System maintenance logs from August 2023 through May 2025 revealed that in October 2024 four of 19 daily maintenance was not performed. 16. A review of the Access 2 System maintenance logs from August 2023 through May 2025 revealed that in October 2024 one of four weekly maintenance was not performed. 17. A review of the Access 2 System maintenance logs from August 2023 through May 2025 revealed that in October 2024 one of four system check results maintenance was not performed. 18. A review of the Access 2 System maintenance logs from August 2023 through May 2025 revealed that in April 2025 three of 18 daily maintenance was not performed. 19. A review of the Sysmex XN 2000 maintenance logs from August 2023 through May 2025 revealed that there was no differentiation for which instrument maintenance was performed on. There was only one table for daily maintenance. 20. An interview with the Technical Consultant on June 17, 2025 at approximately 11:30 AM confirmed these findings. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

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 a review of the temperature logs, and an interview with the Technical Consultant, the laboratory failed to document corrective action when temperatures were out of the acceptable range (36 to 38 degrees Celsius) for the heat block. Findings include: 1. A review of the temperature logs from August 2023 through May 2025 revealed that in August through October 2023 five of 65 days the heat block was out of range. There was no documentation of a corrective action. 2. A review of the temperature logs from August 2023 through May 2025 revealed that in December 2023 three of 20 days the heat block was out of range. There was no documentation of a corrective action. 3. A review of the temperature logs from August 2023 through May 2025 revealed that in January 2024 11 of 23 days the heat block was out of range. There was no documentation of a corrective action. 4. A review of the temperature logs from August 2023 through May 2025 revealed that in April through May 2024 two of 44 days the heat block was out of range. There was no

documentation of a corrective action. 5. A review of the temperature logs from August 2023 through May 2025 revealed that in November 2024 one of 19 days the heat block was out of range. There was no documentation of a corrective action. 6. A review of the temperature logs from August 2023 through May 2025 revealed that in April 2025 one of 22 days the heat block was out of range. There was no documentation of a corrective action. 7. An interview with the Technical Consultant on June 17, 2025 at approximately 10:30 AM confirmed these findings. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

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 a review of the temperature logs and an interview with the Technical Consultant, the laboratory failed to document corrective action when temperatures were out of the acceptable range (-15 to -25 degrees Celsius) for the freezer temperature. Findings include: 1. A review of the temperature logs from August 2023 through May 2025 revealed that in August through December 2023, 22 of 106 days the freezer was out of range. There was no documentation of a corrective action. 2. A review of the temperature logs from August 2023 through May 2025 revealed that in January through August 2024, 24 of 175 days the freezer was out of range. There was no documentation of a corrective action. 3. A review of the temperature logs from August 2023 through May 2025 revealed that in December 2024, one of 21 days the freezer was out of range. There was no documentation of a corrective action. 4. A review of the temperature logs from August 2023 through May 2025 revealed that in March through May 2025, 10 of 65 days the freezer was out of range. There was no documentation of a corrective action. 5. An interview with the Technical Consultant on June 17, 2025 at approximately 10:30 AM confirmed these findings. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

D5791

ANALYTIC SYSTEMS QUALITY ASSESSMENT

CFR(s): 493.1289(a)(c)

(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 analytic systems specified in 493.1251 through 493.1283.

This STANDARD is not met as evidenced by:

Based on a review of the laboratory temperature records for the storage of reagents and specimens, instrument maintenance records, the Quality Assessment (QA) policy, and an interview with the Technical Consultant, the laboratory failed to follow their written procedure to monitor, assess, and correct problems related to analytic systems. Findings include: 1. A review of the instrument maintenance checklists from August 2023 through May 2025, found that daily, weekly, every-other-week, monthly, and/or quarterly maintenance for the AU480 and the Access 2, were not performed and documented according to the manufacturer's instructions. Refer to

D5429. 2. A review of the instrument maintenance checklists from August 2023 through May 2025, found that the daily maintenance for each Sysmex XN 2000 was not documented separately. Refer to D5429. 3. A review of the temperature logs between August 2023 and May 2025 for the heat block found that no corrective action was documented when the heat block was out of the acceptable temperature range. Refer to D5781. 4. A review of the temperature logs between August 2023 and May 2025 for the freezer found that no corrective action was documented when the freezer was out of the acceptable temperature range. Refer to D5785. 5. A review of the QA policy and checklist found that instrument maintenance logs and temperature log reviews were checklist items. All items had been marked as complete between August 2023 and May 2025, but the review was inadequate to detect the errors in quality and correct them. 6. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 3:30 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

D5807

TEST REPORT
CFR(s): 493.1291(d)

(d) Pertinent "reference intervals" or "normal" values, as determined by the laboratory performing the tests, must be available to the authorized person who ordered the tests and, if applicable, the individual responsible for using the test results.

This STANDARD is not met as evidenced by:
Based on a random review of eight patient test reports between September 2023 through May 2025 and an interview with the Technical Consultant, the laboratory failed to provide pertinent reference ranges on the test reports. 1. A review of the eight patient test reports from September 2023 through May 2025, revealed that three of eight patient reports for Comprehensive Metabolic Panel failed to include reference ranges for eGFR. 2. A review of the eight patient test reports from September 2023 through May 2025, revealed that three of eight patient reports for Comprehensive Metabolic Panel failed to include reference ranges for BUN Creat Ratio. 3. An interview with the Technical Consultant on June 17, 2025 at approximately 1:30 PM confirmed these findings. The laboratory performs approximately 206,745 chemistry tests annually.

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 a review of the test reports and the Quality Assessment procedure and checklist, and an interview with the Technical Consultant, the laboratory QA system failed to detect that test reports did not have reference ranges for all analytes. Findings include: 1. A review of the test reports found that estimated glomerular filtration rate (eGFR) and Blood Urea Nitrogen (BUN) Creatinine ratio results did not have reference ranges. Refer to D5807. 2. A review of the QA policy and checklist found that reviewing the reports to ensure that reference ranges were available in the laboratory information system (LIS) and the electronic medical record (EMR) systems

were checklist items. All items had been marked as complete between August 2023 and May 2025, but the review was inadequate to detect the errors in quality and correct them. 3. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 3:30 PM. The laboratory performs approximately 206,745 chemistry tests annually.

D6000

MODERATE COMPLEXITY LABORATORY DIRECTOR
CFR(s): 493.1403

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.

This CONDITION is not met as evidenced by:

Based on the number and severity of the deficiency cited herein, the Condition: [Director] was not met. The director failed to provide adequate management and direction to ensure that initial training was performed and documented, and an adequate quality assurance program was in place to detect errors in general laboratory quality, as well as the analytical, and post-analytical phases of the testing process, and that a complete critical value policy was available. Findings include: 1. Initial training for personnel performing patient testing was not performed and documented. Refer to D6029. 2. The Quality Assessment procedure and checklist were inadequate to detect errors in quality in General Laboratory Systems (Refer to D5291 and D5221). a. Failure to detect missing semi-annual and annual personnel competency. b. Failure to detect missing evaluation of non-graded PT results. c. Failure to detect missing corrective action for unacceptable PT results. 3. The Quality Assessment procedure and checklist were inadequate to detect errors in quality for the analytic phase of testing (Refer to D5791). a. Failure to detect missing instrument maintenance. b. Failure to detect out of range freezer temperatures. c. Failure to detect out of range heat block temperatures. 4. The Quality Assessment procedure and checklist for the post-analytic phase of testing were inadequate to detect missing reference ranges on test reports (Refer to D5891). 5. The laboratory director failed to ensure that there was a complete and current critical value reporting policy available for testing personnel (Refer to D6031). 6. An interview with the Technical Consultant on June 17, 2025 at approximately 11:30 AM confirmed these findings. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

D6029

LABORATORY DIRECTOR RESPONSIBILITIES
CFR(s): 493.1407(e)(11)

(e)(11) Ensure that prior to testing patients specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results;

This STANDARD is not met as evidenced by:

Based on a review of the 2023 and 2025 CMS-209 forms, a review of the personnel competency records, and an interview with the Testing Personnel eight (TP8) and the Technical Consultant, the Laboratory Director failed to ensure that initial training was performed and documented for all testing personnel during their first year of patient

testing. Findings include: 1. A review of the CMS-209 form and the personnel competency records for eight testing personnel found that initial training was not performed and documented for TP8 in 2023. 2. A review of the 2023 and 2025 CMS-209 forms and the personnel competency records found that TP8 was not previously listed as testing personnel. TP8 indicated they had been the back-up testing personnel for hematology since approximately 2022, in an interview on June 17, 2025 at approximately 3:30 PM. 3. The only documented training for TP8 was in 2025. 4. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 2:00 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

D6031

LABORATORY DIRECTOR RESPONSIBILITIES
CFR(s): 493.1407(e)(13)

(e)(13) Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process; and

This STANDARD is not met as evidenced by:
Based on a review of the laboratory policies and procedures, and an interview with the Technical Consultant, the laboratory director failed to ensure that a complete and current critical value reporting policy was available for the testing personnel. Findings include: 1. A review of the critical value policy found that the policy did not contain instructions on appropriate procedures to be performed when a critical value was flagged by the instrument or the laboratory information system (LIS). a. No guidance was available to determine if the specimen should be re-run. b. No guidance was available regarding who critical values were to be reported to. c. No guidance was available regarding what to do if they were unable to contact the appropriate person. 2. A review of the critical value policy found that the table in the policy was not the current table of critical values. A second table that was not part of the policy was available. This table included documentation of three separate updates that were not reflected in the policy. 3. An interview with the Technical Consultant on June 17, 2025 at approximately 11:30 AM confirmed these findings. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.

D6053

TECHNICAL CONSULTANT RESPONSIBILITIES
CFR(s): 493.1413(b)(9)

(b)(9) Evaluating and documenting the performance of individuals responsible for moderate complexity testing at least semiannually during the first year the individual tests patient specimens.

This STANDARD is not met as evidenced by:
Based on a review of the CMS-209 form, a review of the personnel competency records, and an interview with the Testing Personnel eight (TP8) and the Technical Consultant, the Technical Consultant failed to ensure that semi-annual competency assessments were performed and documented for all testing personnel during their first year of patient testing. Findings include: 1. A review of the CMS-209 form and the personnel competency records for eight testing personnel found that semi-annual competency assessments were not performed and documented for Testing Personnel one and two (TP1 and TP2) in 2023. 2. A review of the CMS-209 form and the

	<p>personnel competency records found that TP8 was not previously listed as testing personnel. TP8 indicated they had been the back-up testing personnel for hematology since approximately 2022, in an interview on June 17, 2025 at approximately 3:30 PM. 3. No semi-annual competency assessment was performed and documented for TP8 in 2023 or 2024. 4. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 2:00 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.</p>
<p>D6054</p>	<p>TECHNICAL CONSULTANT RESPONSIBILITIES CFR(s): 493.1413(b)(9)</p> <p>(b)(9) Thereafter, evaluations must be performed at least annually</p> <p>This STANDARD is not met as evidenced by: Based on a review of the CMS-209 form, a review of the personnel competency records, and an interview with the Technical Consultant, the Technical Consultant failed to ensure that annual competency assessments were performed for all testing personnel annual. Findings include: 1. A review of the CMS-209 form and the personnel competency records found that annual competency assessments were not performed and documented for six of eight testing personnel in 2024. 2. A review of the CMS-209 form and the personnel competency records found that annual competency assessments were not performed and documented for one of eight testing personnel in 2025. 3. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 2:00 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.</p>
<p>D6064</p>	<p>TESTING PERSONNEL QUALIFICATIONS CFR(s): 493.1423(a)</p> <p>Each individual performing moderate complexity testing must-- (a) possess a current license issued by the State in which the laboratory is located, if such licensing is required; and</p> <p>This STANDARD is not met as evidenced by: Based on a review of the CMS-209 form, a review of the Division of Public and Behavioral Health (the Division) records, and an interview with the Technical Consultant, the laboratory director failed to ensure that all testing personnel had the appropriate personnel certification from the State of Nevada prior to performing patient testing. Findings include: 1. A review of the CMS-209 form and the Division records revealed that Testing Personnel five (TP5) had the incorrect State personnel certification for moderate complexity testing. 2. TP5 was not certified as an Office Laboratory Assistant (moderate complexity testing). TP5 had a Laboratory Assistant personnel certificate (waived testing) from the State of Nevada. 3. The Technical Consultant confirmed these findings in an interview on June 17, 2025 at approximately 2:00 PM. The laboratory performs approximately 979 general immunology, 206,745 chemistry and 167,928 hematology tests annually.</p>
<p>D6092</p>	<p>LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(4)(iv)</p>

(e)(4)(iv) An approved corrective action plan is followed when any proficiency testing result is found to be unacceptable or unsatisfactory;

This STANDARD is not met as evidenced by:

Based on a review of the laboratory's policies and procedures, a review of the CAP PT evaluations for the Ligand and Reticulocyte PT events from August 2023 through May 2025, and an interview with the Technical Consultant, the laboratory director failed to ensure that the testing personnel followed the corrective action plan when any proficiency testing result is found to be unacceptable or unsatisfactory. Findings include: 1. A review of the laboratory director approved policy titled "Quality Assessment" states that "Any PT results less than 100% are investigated and remedial action is documented on the PT Event Report". 2. A review of the CAP PT evaluations from August 2023 through May 2025 revealed that the second event of 2023 for Reticulocyte sample RT 4-04 was unacceptable. There was no documented investigation or corrective action. 3. A review of the CAP PT evaluations from August 2023 through May 2025 revealed that the results for "hCG, serum quant" were unacceptable for sample K-15 in the third Ligand PT event of 2023. 4. An interview with the Technical Consultant on June 17, 2025 at approximately 12:30 PM confirmed these findings. The laboratory performs approximately 979 general immunology and 167,928 hematology tests annually.