Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	37D0472947	06/19/2025
Name of Provider or Supplier	**Street Address, City, State**	
Urology Center Of Southern Oklahoma, Pc	1119 Walnut Dr, Ste 2, Ardmore, OK	

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	The recertification survey was performed on 06/18.19/2025. The laboratory was found in compliance with standard-level deficiencies cited. The findings were reviewed with the laboratory director, office manager, and testing person #2 at the conclusion of the survey.
D5413	TEST SYSTEMS, EQUIPMENT, INSTRUMENTS, REAGENT CFR(s): 493.1252(b) (b) The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (b)(1) Water quality. (b)(2) Temperature. (b)(3) Humidity. (b)(4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This STANDARD is not met as evidenced by: Based on observation, manufacturer's package insert and interview with testing person #2 and the laboratory director, the laboratory failed to ensure one of one bottle of Multistix Pro 10 LS urine test strips were stored as required by the manufacturer. Findings include: (1) Observation of the laboratory and interview with testing person #2 on 06/18/2025 at 11:00 am, identified the following: (a) One bottle of Multistick Pro 10 LS urine test strips, with the lid removed and no testing person(s) in the immediatie vicinity of the strips. (b) Observation of the laboratory on 06/18/2025 at 11:05 am (five minutes later), identified the same bottle of test strips remained open on the countertop. (2) A review of the manufacturer's package insert stated, "Replace the cap immediately and tightly after removing the reagent strip". (3) Interview with testing person #2 on 06/18/2025 at 11:05 am confirmed the laboratory was not replacing the cap on the test strips between patient use.