Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	37D2020809	06/03/2026
Name of Provider or Supplier	**Street Address, City, State**	
Cpn West Clinic	781 Grand Casino Blvd, Suite 134 Lab, Shawnee, 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 06/02,03/2026. Standard-level deficiencies were cited.
D2014	TESTING OF PROFICIENCY TESTING SAMPLES (b)(6) The laboratory must document the handling, preparation, processing, examination, and each step in the testing and reporting of results for all proficiency testing samples. The laboratory must maintain a copy of all records, including a copy of the proficiency testing program report forms used by the laboratory to record proficiency testing results including the attestation statement provided by the PT program, signed by the analyst and the laboratory director, documenting that proficiency testing samples were tested in the same manner as patient specimens, for a minimum of two years from the date of the proficiency testing event. This STANDARD is not met as evidenced by: Based on a review of records and interview with technical consultant #1, the laboratory director or designee failed to sign proficiency testing attestation statements for one of one supplemental bilirubin events reviewed in 2025. Findings include: (1) On 06/02/2026, a review of the 2025 chemistry supplemental bilirubin testing event identified the following for one of one events: (a) 2025 Supplemental Bilirubin Event - The attestation statement had not been signed by the laboratory director. (2) The findings were reviewed with technical consultant #1, who stated on 06/02/2026 at 11: 30 am, the attestation statemen had not been signed by the laboratory director or designee.
D5211	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(a) The laboratory must review and evaluate the results obtained on proficiency testing

	performed as specified in subpart H of this part. This STANDARD is not met as evidenced by: Based on a review of records and interview with technical consultant #1, the laboratory failed to review and evaluate proficiency testing results for two of eight proficiency testing events reviewed in 2025 and 2026. Findings include: (1) On 06/02 /2026, a review of Chemistry and Hematology proficiency testing from American Proficiency Institute (API) records for 2025 (first, second, and third events) and 2026 (first event) identified the following biases (biases were identified using the SDI (Standard Deviation Index) values assigned by the proficiency program) for one of four events: (a) 2025 - API Hematology/Coagulation 3rd Event (i) MCH - five of five results exhibited a positive bias: (aa) Sample XE-11 - SDI of 2.4 (bb) Sample XE-12 - SDI of 3.7 (cc) Sample XE-13 - SDI of 2.4 (dd) Sample XE-14 - SDI of 1.9 (ee) Sample XE-15 - SDI of 1.6 (ii) MCHC - five of five events exhibited a positive bias: (aa) Sample XE-11 - SDI of 2.8 (bb) Sample XE-12 - SDI of 3.5 (cc) Sample XE-13 - SDI of 2.4 (dd) Sample XE-14 - SDI of 1.6 (ee) Sample XE-15 - SDI of 2.0 (b) 2026 - API Chemistry Core 1st Event (i) Folate - five of five results exhibited a positive bias (aa) Sample IA-01 - SDI of 4.2 (bb) Sample IA-02 - SDI of 3.5 (cc) Sample IA-03 - SDI of 1.9 (dd) Sample IA-04 - SDI of 2.8 (ee) Sample IA-05 - SDI of 2.9 (2) There was no evidence in the records to prove the biases had been identified and addressed; (3) The records were reviewed with technical consultant #1, who stated on 06/02/2026 at 02:30 pm, the biases had not been identified and addressed.
D5401	PROCEDURE MANUAL CFR(s): 493.1251(a) (a) A written procedures manual for all tests, assays, and examinations performed by the laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory's written procedures for testing or examining specimens. This STANDARD is not met as evidenced by: Based on review of policy and interview with technical consultant #1, the laboratory failed to follow their policy for urine centrifuge speed and time checks for one of one centrifuge used. Findings include: (1) On 06/03/2026 am, technical consultant #1 stated the laboratory performed urine microscopic testing; (2) A review of the policy titled "Centrifuge Speed Verification" stated the following: (a) "All centrifuges must be initially evaluated by the laboratory personnel for use in the clinical laboratory. Every six months the rotational speed is verified by using the digital tachometer". (3) A review of records revealed no documentation that the urine centrifuge speed and time had been verified between 06/18/2025 and the current date"; (4) Interview with technical consultant #1 on 06/03/2026 at 11:45 am, confirmed the laboratory failed to follow their policy for centrifuge speed and time verification.