Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	37D2170608	04/16/2025
Name of Provider or Supplier	**Street Address, City, State**	
Dean Mcgee Eye Institute Pathology Services	608 Stanton L Young Blvd, Oklahoma City, 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 04/16/2025. The laboratory was found in compliance with standard-level deficiencies cited. The findings were reviewed with the laboratory director and technical supervisor at the conclusion of the survey.
D5209	PERSONNEL COMPETENCY ASSESSMENT POLICIES CFR(s): 493.1235 As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency. This STANDARD is not met as evidenced by: Based on a review of records, written policies and procedures, and interview with the laboratory director and technical supervisor, the laboratory failed to have a written policy to assess the competency of the technical supervisor and general supervisor, based on the position responsibilities as listed in Subpart M, for one of one person. Findings include: (1) A review of the laboratory policy and procedure manual identified no evidence of a policy for assessing the competency of the technical supervisor and general supervisor, including the frequency of the assessments; (2) A review of the Form CMS-209 (Laboratory Personnel Report) and personnel records for competency assessments performed during the review period of January 2024 through the current date identified competencies, based on job responsibilities, had not been performed for one of one person listed as the general supervisor and technical supervisor; (3) The findings were reviewed with the laboratory director and technical supervisor. Both stated on 04/16/2025 at 09:55 am, a policy had not been written and competencies had not been performed for the positions as stated above.
D5217	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1)

	At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part. This STANDARD is not met as evidenced by: Based on a review of records and interview with the laboratory director and technical supervisor, the laboratory failed to verify the accuracy of slide interpretations at least twice annually during the review period of January 2024 through the current date. Findings include: (1) On 04/16/2025 at 09:05 am, the technical supervisor stated the laboratory performed microscopic interpretations of ophthalmic specimens; (2) A review of records for testing performed from January 2024 through the current date identified no documentation to show the accuracy of the slide interpretations had been verified for accuracy at least twice annually; (3) The findings were reviewed with the laboratory director who stated on 04/16/2025 at 09:20 am, there was no documentation the slide interpretations had been verified for accuracy twice annually during the review period.
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 a review of records and interview with the laboratory director and technical supervisor, the laboratory failed to ensure patient test reports included the name, as stated on the CLIA certificate, and address of the laboratory location where the testing was performed for five of five reports reviewed. Findings include: (1) On 04/16/2025 at 09:05 am, the technical supervisor stated the laboratory performed grossing and microscopic interpretations of ophthalmic specimens; (2) A review of five patient reports identified the laboratory name, as stated on the CLIA certificate (Dean McGee Eye Institute Pathology Services) and/or the address of the laboratory location where the testing was performed were not included as follows: (a) Patient DM24-00040 reported on 01/18/2024 - The name was listed as CC DMOHC Lab; (b) Patient DM24-00650 reported on 08/26/2024 - The name was listed as CC DMOHC Lab and the address of the laboratory location was not included; (c) Patient DM24-00943 reported on 11/19/2024 - The name was listed as Dean McGee Eye Institute - HSC; (d) Patient DM25-00010 reported on 01/15/2025 - The name and address of the laboratory location were not included; (e) Patient DM25-00100 reported on 02/06/2025 - The name and address of the laboratory location were not included. (3) The records were reviewed with the laboratory director and technical supervisor. Both stated on 04/16 /2025 at 10:10 am, the laboratory name and/or address had not been included on the patient test reports as stated above.