Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	38D0622163	01/10/2018
Name of Provider or Supplier	**Street Address, City, State**	
Providence Medical Group Molalla	110 Center Ave, Molalla, OR	

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
D2128	HEMATOLOGY CFR(s): 493.851(e) (1) For any unsatisfactory analyte or test performance or testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure. (2) For any unacceptable analyte or testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event. This STANDARD is not met as evidenced by: Based upon review of Proficency Testing (PT) records and discussion with the Laboratory Director (LD) and Testing Personnel, the laboratory failed to document Corrective Action (CA) taken on a failed hematology PT event in 2016. Findings include: 1. The third PT event from 2016 had a Platelet count result that was graded unsatisfactory. There was no documentation of any CA taken for this failure. 2. The testing personnel responsible for the failed PT result confirmed that no CA had been performed.
D6018	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(4)(iii) The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, and record and report test results promptly, accurate, and proficiently and for assuring compliance with the applicable regulations. (e) The laboratory director must-- (e)(4)(iii) Ensure that all proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratory's performance and to identify any problems that require corrective action;

	This STANDARD is not met as evidenced by: Based upon review of Proficency Testing (PT) records and discussion with the Laboratory Director (LD), the LD failed to review the failed PT for Hematology, event three (3) in 2016. Findings include: 1. No written documentation regarding acknowledement of the failure by the LD could be provided during the survey. 2. No written documentation regarding Corrective Action (CA) taken by the LD could be provided during the survey.