Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	39D0199671	05/21/2026
Name of Provider or Supplier	**Street Address, City, State**	
Moss Rehab Einstein At Elkins Park	60 East Township Line Road, Elkins Park, PA	

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	A validation survey was conducted by the Pennsylvania State Agency for Moss Rehab Einstein at Elkins Park on 5/21/2026. The laboratory was found out of compliance with the following conditions: 493.1250 Condition: Analytic Systems 493.1403 Condition: Laboratories performing moderate complexity testing; laboratory director. 493.1421 Condition: Laboratories performing moderate complexity testing; testing personnel.
D3009	FACILITIES CFR(s): 493.1101(c) The laboratory must be in compliance with applicable Federal, State, and local laboratory requirements. This STANDARD is not met as evidenced by: Based on record review, lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to monitor and document temperature and humidity to ensure operating conditions were met when 1 of 1 chemistry test (Whole Blood Glucose) was performed using the Roche Inform II glucose meter from 5/21 /2024 to 5/21/2026. Findings include: 1. On the day of the survey, 5/21/2026 at 1:30 pm, review of the manufacturer's instruction for use stated, " Use the test strips at temperatures between 4 to 30 degrees Celsius. Use the test strips between 10 - 80% relative humidity." 2. The laboratory failed to provide documentation for temperature and humidity readings taken to ensure operating conditions were met for 1 of 1 chemistry test (Whole Blood Glucose) performed using the Roche Inform II glucose meter from 5/21/2024 to 5/21/2026. 3. The POCC confirmed the findings above on 5 /21/2026 at 2:00 pm.
D3031	RETENTION REQUIREMENTS CFR(s): 493.1105(a)(3)

	Analytic systems records. Retain quality control and patient test records (including instrument printouts, if applicable) and records documenting all analytic systems activities specified in 493.1252 through 493.1289 for at least 2 years. In addition, retain the following: This STANDARD is not met as evidenced by: Based on lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to retain analytic systems records for 2 of 2 years as required from 5/21/2024 to 5/21/2026. Findings include: 1. On the day of survey, 5/21 /2026 at 11:45 am, the laboratory failed to provide documentation of the following analytic system records for 2 of 2 years as required from 5/21/2024 to 5/21/2026: - 2024 and 2025 - Refrigerator, room temperature and room humidity logs - 5/21/2024 to 5/21/2026 - Maintenance logs for Siemens EPOC analyzers - 5/21/2024 to 5/21 /2026 - New lot of reagent validations - 5/21/2024 to 5/21/2026 - Quality Control audits to be performed per policy by the POCC 2. The laboratory performed 1526 examinations in 2025 (CMS 116 estimated annual volume, dated 5/21/2026). 3. The POCC confirmed the above findings on 5/21/2026 at 12:30 pm.
D3037	RETENTION REQUIREMENTS CFR(s): 493.1105(a)(4) (a)(4) Proficiency testing records. Retain all proficiency testing records for at least 2 years. This STANDARD is not met as evidenced by: Based on review of College of American Pathologists (CAP) proficiency testing (PT) records and interview with the Point of Care Coordinator (POCC), the laboratory failed to retain the documentation for 1 of 6 CAP PT events performed from 5/21 /2024 to 12/31/2025. Findings include: 1. On the day of survey, 5/21/2026 at 10:25 am, the laboratory could not provide the documentation for the following 1 of 6 CAP PT events performed in 2024: - CAP AQHC 2024 2. The POCC confirmed the above findings on 5/21/2026 at 12:30 pm.
D5205	COMPLAINT INVESTIGATIONS CFR(s): 493.1233 The laboratory must have a system in place to ensure that it documents all complaints and problems reported to the laboratory. The laboratory must conduct investigations of complaints, when appropriate. This STANDARD is not met as evidenced by: Based on lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to establish and maintain a policy to ensure all complaints and problems reported to the laboratory were documented and investigated when needed for 2 of 2 years from 5/21/2024 to 5/21/2026. Findings include: 1. On the day of survey, 5/21/2026 at 11:30 am, the laboratory could not provide a policy to ensure all complaints and problems reported to the laboratory were documented and investigated as needed for 2 of 2 years from 5/21/2024 to 5/21/2026. 2. The POCC confirmed the above findings on 5/21/2026 at 11:45 am.

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 lack of documentation and interview with the Point of Care Coordinator (POCC), the laboratory failed to establish and follow a competency assessment (CA) procedure to assess the competency of 1 of 1 Technical Consultant (TC) for their supervisory responsibilities performed from 5/21/2024 to 5/21/2026. Findings Include: 1. On the day of survey, 5/21/2026 at 11:30 am, the laboratory failed to provide a competency assessment procedure to assess the competency of 1 of 1 TC (CMS 209, TC # 1 dated 5/21/2026) for their supervisory responsibilities performed in the laboratory from 5/21/2024 to 5/21/2026. 2. The laboratory failed to provide CA records for TC #1 for their supervisory responsibilities performed from 5/21/2024 to 5 /21/2026. 3. The laboratory performed 1526 examinations in 2025 (CMS 116 estimated annual volume, dated 5/21/2026). 4. The POCC confirmed the findings above on 5/21 /2026 at 11:50 am.
D5301	TEST REQUEST CFR(s): 493.1241(a) (a) The laboratory must have a written or electronic request for patient testing from an authorized person. This STANDARD is not met as evidenced by: Based on record review, lack of documentation and interview with the Point of Care Coordinator (POCC), the laboratory failed to have written or electronic requests from an authorized person for blood gas patient testing performed for 2 of 2 years from 5/21 /2024 to 5/21/2026. Findings include: 1. On the date of the survey, 5/21/2026 at 1:30 pm, the laboratory could not provide written or electronic test requisitions from an authorized person for blood gas testing performed for 2 of 2 years from 5/21/2024 to 5 /21/2026. 2. The laboratory performed 1526 examinations (CMS 116 estimated annual volume, dated 5/21/2026). 3. The POCC confirmed the above findings on 5/21/2026 at 1:45 pm.
D5400	ANALYTIC SYSTEMS CFR(s): 493.1250 Each laboratory that performs nonwaived testing must meet the applicable analytic systems requirements in 493.1251 through 493.1283, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub.7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the analytic systems and correct identified problems as specified in 493.1289 for each specialty and subspecialty of testing performed. This CONDITION is not met as evidenced by: Based on observation of the laboratory, record review, lack of documentation, and

	interview with the Point of Care Coordinator (POCC), the laboratory failed to meet applicable analytic systems requirements in 493.1251 through 493.1283 for 2 of 2 years from 5/21/2024 to 5/21/2026. Refer to 5429, 5439, 5445, 5775, and 5781.
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 observation of the laboratory, lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to assess the maintenance and function checks as defined by the manufacturer for 1 of 1 thermometer used to record room temperature and humidity in the laboratory when blood gas testing was performed from 5/21/2024 to 5/21/2026. Findings Include: 1. On the day of the survey, 5/21/2026 at 1:45 pm, observation of the laboratory revealed 1 of 1 room temperature and humidity thermometer with no expiration date, serial number or identifying label on the instrument. 2. The laboratory could not provide maintenance /function check records for the 1 of 1 thermometer used to record room temperature and humidity in the laboratory when blood gas testing was performed from 5/21/2024 to 5/21/2026. 3. The POCC confirmed the above findings on 5/21/2026 at 2:00 pm.
D5439	CALIBRATION AND CALIBRATION VERIFICATION CFR(s): 493.1255(b) (b)(1) Following the manufacturer's calibration verification instructions; (b)(2) Using the criteria verified or established by the laboratory under 493.1253(b)(3)-- (b)(2)(i) Including the number, type, and concentration of the materials, as well as acceptable limits for calibration verification; and (b)(2)(ii) Including at least a minimal (or zero) value, a mid-point value, and a maximum value near the upper limit of the range to verify the laboratory's reportable range of test results for the test system; and (b)(3) At least once every 6 months and whenever any of the following occur: (b)(3)(i) A complete change of reagents for a procedure is introduced, unless the laboratory can demonstrate that changing reagent lot numbers does not affect the range used to report patient test results, and control values are not adversely affected by reagent lot number changes. (b)(3)(ii) There is major preventive maintenance or replacement of critical parts that may influence test performance. (b)(3)(iii) Control materials reflect an unusual trend or shift, or are outside of the laboratory's acceptable limits, and other means of assessing and correcting unacceptable control values fail to identify and correct the problem. (b)(3)(iv) The laboratory's established schedule for verifying the reportable range for patient test results requires more frequent calibration verification. This STANDARD is not met as evidenced by: Based on lack of documentation and interview with the Point of Care Coordinator (POCC), the laboratory failed to perform calibration verification at least once every six months for 2 of 2 Siemens Epoc Blood Gas analyzers from 5/21/2024 to 5/21 /2026. Findings include: 1. On the date of survey, 5/21/2026 at 12:00 pm, the laboratory failed to provide calibration verification records performed at least once every 6 months for the following analytes tested on 2 of 2 Siemens Epoc Blood Gas analyzers from 5/21/2024 to 5/21/2026. - pH - PCO2 - PO2 -Sodium -Potassium -

	Chloride -Calcium -Creatinine -Blood Urea Nitrogen -Glucose -Hematocrit -Lactate 2. The laboratory performed 1526 chemistry examinations in 2025 (CMS 116, estimated annual volume dated 5/21/2026). 3. The POCC confirmed the findings above on 5/21/2026 at 01:30 pm.
D5445	CONTROL PROCEDURES CFR(s): 493.1256(d)(1)(2)(g) (d) Unless CMS Approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing, the laboratory must-- (d)(1) Perform control procedures as defined in this section unless otherwise specified in the additional specialty and subspecialty requirements at 493. 1261 through 493.1278. (d)(2) For each test system, perform control procedures using the number and frequency specified by the manufacturer or established by the laboratory when they meet or exceed the requirements in paragraph (d)(3) of this section. (d)(3) At least once each day patient specimens are assayed or examined perform the following for: This STANDARD is not met as evidenced by: Based on review of quality control (QC) records and interview with the Point of Care Coordinator (POCC), the laboratory failed to perform QC procedures as required for blood gas testing performed on 2 of 2 Siemens EPOC analyzers at least once each day of patient testing from 5/21/2024 to 5/21/2026. Findings include: 1. On the day of survey, 5/21/2026 at 01:00 pm, review of the laboratory's QC records revealed the laboratory failed to ensure QC was performed on 2 of 2 Siemens EPOC analyzers at least once each day of patient testing from 5/21/2024 to 5/21/2026. 2. Further review of QC records revealed the laboratory performed external QC for blood gas testing monthly. The laboratory failed to provide an Individualized Quality Control Plan (IQCP). 3. The laboratory performed 1526 examinations in 2025 (CMS 116 estimated annual volume, dated 5/21/2026). 4. The POCC confirmed the findings above on 5/21 /2026 at 01:30 pm.
D5775	COMPARISON OF TEST RESULTS CFR(s): 493.1281(a)(c) (a) If a laboratory performs the same test using different methodologies or instruments, or performs the same test at multiple testing sites, the laboratory must have a system that twice a year evaluates and defines the relationship between test results using the different methodologies, instruments, or testing sites. This STANDARD is not met as evidenced by: Based on lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to evaluate twice a year the relationship between test results using different instruments/methodologies for blood gas examinations performed on 2 of 2 EPOC blood gas analyzers from 5/21/2024 to 5/21/2026. Findings include: 1. On the day of the survey, 5/21/2026 at 1:10 pm, the laboratory failed to provide documentation for the evaluation performed twice a year to monitor and evaluate the relationship between test results using different instruments /methodologies for blood gas examinations performed on 2 of 2 EPOC blood gas

	analyzers from 5/21/2024 to 5/21/2026. 2. The laboratory performed 1526 chemistry examinations in 2025 (CMS 116, estimated annual volume dated 5/21/2026). 3. The POCC confirmed the findings above on 5/21/2026 at 1:30 pm.
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 review of the laboratory's temperature log records and interview with the Point of Care Coordinator (POCC), the laboratory failed to document corrective actions taken when room humidity did not meet the laboratory's established acceptable range for 28 of 28 days to ensure reliable test system operation of the Siemens EPOC analyzers for blood gas testing performed from 2/1/2026 to 2/28/2026. Findings include: 1. On the day of the survey, 05/21/2026 at 12:15 pm, review of the laboratory's Temperature and Humidity Log revealed the laboratory's established acceptable range for relative humidity to ensure reliable test system operation of the Siemens EPOC analyzers was indicated as 15 to 88%. 2. Further review of the laboratory's Room Temperature and Humidity Log revealed the laboratory documented a relative humidity reading of 10 % for 28 of 28 days when blood gas testing was performed from 2/1/2026 to 2/28/2026. 3. The laboratory failed to provide documentation for the corrective actions taken when the relative humidity fell outside of the laboratory's acceptable established ranges for 28 of 28 days from 2/1/2026 to 2 /28/2026. 4. The POCC confirmed the finding above on 5/21/2026 at 12:30 pm.
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 record review, lack of documentation, and interview with the Point of Care Coordinator (POCC), the laboratory failed to establish and maintain written policies for an ongoing mechanism to monitor, assess and when indicated, correct problems identified in the postanalytic systems specified in 493.1291 for 2 of 2 years from 5/21 /2024 to 5/21/2026. Findings include: 1. On the day of survey, 5/21/2026 at 12:15 pm, the laboratory could not provide a procedure for the ongoing mechanism to monitor, assess, and correct problems found in the postanalytic system specified in 493.1291 for 2 of 2 years from 5/21/2024 to 5/21/2026. 2. The laboratory failed to provide records for the following periodic checks performed to verify the accuracy of the

	Laboratory's Information System (LIS) from 5/21/2024 to 5/21/2026: - Calculated Data - Patient results transmitted between instruments and LIS 3. The POCC confirmed the above findings on 5/21/2026 at 12:50 pm.
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 lack of documentation, and interview with the Point of Care Coordinator (POCC), the Laboratory Director failed to provide overall management and direction of the laboratory in accordance with 493.1407 for a moderate complexity laboratory for 2 of 2 years from 5/21/2024 to 5/21/2026. Refer to 6005, 6018, and 6020.
D6005	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(c) (c) The laboratory director must: (c)(1) Be onsite at least once every 6 months, with at least 4 months between the minimum two on-site visits. Laboratory directors may elect to be on-site more frequently and must continue to be accessible to the laboratory to provide telephone or electronic consultation as needed; and (c)(2) Provide documentation of these visits, including evidence of performing activities that are part of the laboratory director responsibilities. This STANDARD is not met as evidenced by: Based on lack of documentation and interview with the Point of Care Coordinator, the laboratory director failed to be onsite at least once every 6 months, with at least 4 months between the minimum two on-site visits for 2 of 2 years from 5/21/2024 to 5 /21/2026. Findings include: 1. One the day of survey, 5/21/2026, at 12:00 pm, the laboratory failed to provide documentation of the laboratory director's on site visits performed for 2 of 2 years from 5/21/2024 to 5/21/2026. 2. The POCC confirmed the above finding on 5/21/2026 at 2:00 pm.
D6018	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(4)(iii) (e)(4)(iii) All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratorys performance and to identify any problems that require corrective action; and This STANDARD is not met as evidenced by: A. Based on review of the laboratory's College of American Pathologists (CAP) proficiency testing (PT) records and interview with the Point of Care Coordinator (POCC), the laboratory director (LD) failed to ensure that 6 of 6 CAP PT reports were reviewed by the appropriate staff to evaluate the laboratory's performance and to identify any problems that require corrective action from 5/21/2024 to 5/21/2026. Findings include: 1. The Laboratory Policy for POC QC and QI Program stated, "The

	evaluation initial review is performed by the QA manager or the Manager of the unit receiving the evaluation. The POCC then reviews the evaluation. This review is evidenced by the signature and date. All evaluations are reviewed and signed by the Medical Director". 2. On the day of survey, 5/21/2026, at 10:00 am, review of the laboratory's CAP PT records revealed the LD failed to ensure that 6 of 6 CAP PT reports were reviewed by the Medical director as required by policy to evaluate the laboratory's performance and to identify any problems that require corrective action from 5/21/2024 to 5/21/2026. 3. The POCC confirmed the findings above on 5/21 /2026 at 11:45 am B. Based on review of the laboratory's College of American Pathologists (CAP) proficiency testing (PT) records and interview with the Point of Care Coordinator (POCC), the laboratory director (LD) failed to ensure that 3 of 6 CAP PT reports were evaluated to determine corrective actions needed for results that were unacceptable or ungraded from 5/21/2024 to 5/21/2026. Findings include: 1. CAP's Performance Evaluation instructions stated, "Laboratories should review the Performance Summary and Comparative Evaluation thoroughly for failures or 'not graded' analytes. Laboratories are responsible for documenting and performing corrective action for failures and must perform a self-evaluation using statistics presented in the Participant Data summary for samples that have not been graded." 3. On the day of survey, 5/21/2026, at 10:00 am, review of the laboratory's CAP PT records revealed the laboratory failed to determine corrective actions needed for results that were unacceptable or ungraded for the following 3 of 6 CAP PT testing events from 5/21/2024 to 5/21/2026. - CAP AQHA 2025: AQ-01:Creatinine result of 1.54 (Acceptable: 1.19-1.21), no corrective action documented. - CAP AQHB 2025: AQ-09: Creatinine result of 4.83 (Acceptable: 3.93-4.81), no corrective action documented. - CAP AQHB 2025: AQ06-AQ10: Sodium: See note (11) no self evaluation for ungraded results. - CAP AQHB 2025: HCT06-HCT10: Hemoglobin: See note (42), no self evaluation for ungraded results. - CAP AQHA 2026: No testing reported to CAP for this event. 4. The POCC confirmed the findings above on 5/21 /2026 at 11:45 am.
D6020	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(e)(5) (e)(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur; This STANDARD is not met as evidenced by: Based on lack of documentation, and interview with the Point of Care Coordinator (POCC), the Laboratory Director (LD) failed to ensure a Quality Assessment (QA) program was developed and maintained to assure the quality of laboratory services provided for Blood Gas analyses performed for 2 of 2 years from 5/21/2024 to 5/21 /2026. Findings include: 1. On the day of survey, 5/21/2026, at 10:30 am, the laboratory failed to provide a procedure and documentation for the QA activities performed to assure the quality of laboratory services provided for Blood Gas analyses performed for 2 of 2 years from 5/21/2024 to 5/21/2026. 2. The POCC confirmed above findings on 5/21/2026 at 11:45 am.
D6051	TECHNICAL CONSULTANT RESPONSIBILITIES CFR(s): 493.1413(b)(8)(v) (b)(8)(v) Assessment of test performance through testing previously analyzed

	specimens, internal blind testing samples or external proficiency testing samples; and This STANDARD is not met as evidenced by: Based on policy and record review, lack of documentation, and interview with the Point of Care Coordinator (POCC), the Technical Consultant (TC) failed to evaluate the test performance of 7 of 7 testing personnel (TP) through internal blind testing or external proficiency testing (PT) samples for blood gas examinations (Chemistry) performed from 5/21/2024 to 5/21/2026. Findings Include: 1. On the day of the survey, 5/21/2026, at 10:00 am, review of the laboratory's policy titled "POC QC and QI Program" stated, "Competency testing is assessed using (but not limited to) the following 6 methods for non-waived tests: Performance of a test on a previously analyzed specimen, a blind sample or external proficiency testing sample Periodic observation by a supervisor or qualified designee of routine testing including patient identification and preparation, specimen collection and testing. Direct observation of performance of instrument maintenance and/or function checks, as applicable Monitoring of each user's quality control performance, proficiency testing results, or intermediate test results or worksheets Evaluation of problem solving skills Monitoring the recording and reporting of test results, including (as applicable) reporting critical results." 2. The laboratory could not provide documentation for the evaluation of test performance through internal blind testing or external proficiency testing (PT) samples for blood gas examinations (Chemistry) performed for 7 of 7 TP (CMS 209, TP # 1 - #7 dated 5/21/2026) from 5/21/2024 to 5/21/2026. 3. The POCC confirmed the findings above on 5/21/2026 at 11:30 am.
D6063	LABORATORY TESTING PERSONNEL CFR(s): 493.1421 The laboratory must have a sufficient number of individuals who meet the qualification requirements of 493.1423, to perform the functions specified in 493. 1425 for the volume and complexity of tests performed. This CONDITION is not met as evidenced by: Based on review of personnel qualification records and interview with the Point of Care Coordinator (POCC), the laboratory failed to ensure 1 of 7 TP (CMS 209, personnel #4, dated 5/21/2026) met the minimum educational requirements under 493.1423 to perform moderate complexity testing from 5/21/2024 to 5/21/2026. Refer to D6065.
D6065	TESTING PERSONNEL QUALIFICATIONS CFR(s): 493.1423(b)(1)(2)(3)(4)(i) (b) Meet one of the following requirements: (b)(1) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; or (b)(2) Have earned a doctoral, master's, or bachelor's degree in a chemical, biological, clinical or medical laboratory science, or medical technology, or nursing from an accredited institution; or (b)(3) Meet the requirements in 493.1405(b)(3)(i)(B), (b)(4)(i)(B), (b)(4)(i)(C) or (b)(5)(i)(B); or (b)(4) Have earned an associate degree in a chemical, biological, clinical or medical laboratory science, or medical laboratory technology or nursing from an accredited institution; or (b)(5) Be a high school graduate or equivalent and have successfully completed an official military medical laboratory procedures course of at least a duration of 50

	weeks and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician); or (b)(6)(i) Have earned a high school diploma or equivalent; and This STANDARD is not met as evidenced by: Based on review of personnel qualification records and interview with the Point of Care Coordinator (POCC), the laboratory failed to ensure that 1 of 7 testing personnel (TP) met the minimum educational requirements to perform moderate complexity testing from 5/21/2024 to 5/21/2026. Findings Include: 1. On the day of survey, 5/21 /2026 at 10:00 am, the laboratory failed to provide an evaluation of the education credentials from outside the United States for 1 of 7 TP (CMS 209 personnel #4, dated 5/21/2026) who performed moderate complexity (chemistry) examinations from 5/21/2024 to 5/21/2026. 2. The POCC confirmed the findings above on 5/21/2026 at 11:50 am.