Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	45D2236424	08/19/2026
Name of Provider or Supplier	**Street Address, City, State**	
Quest Diagnostics Oncology Consultants	7121 South Padre Island Drive, Ste 119, Corpus Christi, TX	

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
D2010	TESTING OF PROFICIENCY TESTING SAMPLES CFR(s): 493.801(b)(2) (b)(2) The laboratory must test samples the same number of times that it routinely tests patient samples. This STANDARD is not met as evidenced by: Based on review of the laboratory College of American Pathologist's (CAP) proficiency testing records from 2026, and staff interview, the laboratory failed to ensure proficiency testing samples were tested the same number of times as patient samples for 10 of 10 samples. The findings included: 1. A review of the laboratory's College of American Pathologist's proficiency testing records from 2026 (Events 1 and 2) determined the laboratory tested 10 of 10 samples twice. a) FH9A - 2026 Test Date: 02/06/2026 Sample: 01 Rack 25 position 1 test time: 13:15 Rack 26 position 1 test time: 13:24 Sample: 02 Rack 25 position 2 test time: 13:16 Rack 26 position 2 test time: 13:25 Sample: 03 Rack 25 position 3 test time: 13:18 Rack 26 position 3 test time: 13: 26 Sample: 04 Rack 25 position 4 test time: 13:19 Rack 26 position 4 test time: 13:27 Sample: 05 Rack 25 position 5 test time: 13:20 Rack 26 position 5 test time: 13:29 b) FH9B - 2026 Sample: 06 Rack 27 position 1 test time: 14:43 Rack 28 position 1 test time: 14:51 Sample: 07 Rack 27 position 2 test time: 14:44 Rack 28 position 2 test time: 14:53 Sample: 08 Rack 27 position 3 test time: 14:46 Rack 28 position 3 test time: 14:54 Sample: 09 Rack 27 position 4 test time: 14:47 Rack 28 position 4 test time: 14:55 Sample: 10 Rack 27 position 5 test time: 14:48 Rack 28 position 5 test time: 14:56 2. Testing personnel number 1 (as listed on Form CMS 209) on 08/19/2026 at 1035 hours in the laboratory stated the samples were tested in duplicate to verify the results. She stated patient samples were routinely only tested 1 time. This confirmed the findings.
D5813	TEST REPORT

	CFR(s): 493.1291(g) (g) The laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values. This STANDARD is not met as evidenced by: Based on review of the laboratory's policies, review of patient test records from August 17, 2026, and staff interview, the laboratory failed to have documentation of the notification of 4 of 4 critical values. The findings included: 1. The laboratory's document titled "Priority 1 & CALL U Outbound Job Aid Weekday Process" (Effective date: 10-Nov-2025) defined the laboratory's critical values as: White blood cell less than or equal to 1.5 greater than or equal to 440 Red blood cell greater 8.6 Hemoglobin less than 7.0 greater than 19.0 Hematocrit less than or equal to 21.0 greater than or equal to 57.0 Platelets less than or equal to 30 greater than 1000 2. A review of patient test records from August 17, 2026 identified 4 patients with critical values, however, the laboratory failed to have documentation of the notification of the provider. They were: a) Sample: DZ794882X02 Hemoglobin: 6.8 b) Sample: DZ788190X02 Platelet: 1598 c) Sample: DZ784566X03 Platelet: 3 d) Sample: DZ783674X02 White blood cell: 1.3 Hemoglobin: 6.7 Hematocrit: 20.7 Platelet: 3 3. The technical consultant confirmed the findings in an interview conducted on 08/17 /2026 at 1130 hours in the laboratory.