Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	46D1023943	10/15/2019
Name of Provider or Supplier	**Street Address, City, State**	
Riverwoods Urgent Care	280 W River Park Dr, Ste 120, Provo, UT	

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
D5779	CORRECTIVE ACTIONS CFR(s): 493.1282(a) Corrective action policies and procedures must be available and followed as necessary to maintain the laboratory's operation for testing patient specimens in a manner that ensures accurate and reliable patient test results and reports. This STANDARD is not met as evidenced by: Based on proficiency testing reports review, lack of documentation and interview with staff, the laboratory failed to have a corrective action policy for staff to follow, after consecutive proficiency testing failures, to document the laboratory's operation for testing and reporting patient microscopic urinalysis and potassium hydroxide specimen testing was accurate and reliable. The laboratory performed approximately 5 microscopic tests monthly. Findings include: 1. The laboratory failed 3 of 4 microscopic urinalysis and vaginal specimen challenges for American Academy of Family Physicians (AAFP) proficiency testing events A and B of 2019. 2. The laboratory corrective action was to review the specimens to educate testing personnel. 3. In an interview with staff on 10/15/2019 at approximately 5:00 P.M. staff confirmed the laboratory did not have a procedure to document patient specimens were being performed accurately after 2 failed events.
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 on proficiency testing (PT) records review, lack of documentation, and confirmation by staff, the laboratory director failed to ensure all proficiency tests are reviewed to evaluate the laboratory's performance and to identify any problems that require corrective action for 2 of 5 testing events reviewed from October 2017 to October 2019. Findings include: 1. American Academy of Family Practice (AAFP) PT reports reviewed failed to include documentation the director reviewed the reports to evaluate test performance for events B and C of 2018. 2. PT records review included hand written microscopic results for 2018 AAFP event B that were not entered in the AAFP proficiency test agency report form to facilitate grading by AAFP. 3. In an interview with staff on 10/15/2019 at approximately 5:00 P.M. staff confirmed PT events B and C of 2018 lacked documentation the results for complete blood counts, microscopic urinalysis, and potassium hydroxide tests were reviewed to evaluate test performance or that 2018 event B microscopic results not reported were evaluated
D6054	TECHNICAL CONSULTANT RESPONSIBILITIES CFR(s): 493.1413(b)(9) The technical consultant is responsible for evaluating and documenting the performance of individuals responsible for moderate complexity testing at least annually, after the first year. This STANDARD is not met as evidenced by: Based on lack of documentation and confirmation by the laboratory manager, the technical consultant failed to evaluate the performance of 3 of 3 testing personnel for complete blood count (CBC) testing and 2 of 2 testing personnel annually for microscopic urinalysis and potassium hydroxide (KOH) annually in 2018. The laboratory performed approximately 30 CBC tests per month. and approximately 3 microscopic tests per month. Findings include: 1. The laboratory failed to evaluate CBC and Microscopic testing personnel annually in 2018 to document personnel collected, labeled and processed specimens in a manner ensuring integrity and identification, that testing was performed accurately, that quality control and instrument maintenance was performed according to the manufacturer instructions, that results were entered into the patient's test record by the laboratory's approved method and that testing personnel performed blind testing or proficiency testing. 2. In an interview conducted on 10/15/2019 at approximately 5:00 P.M. staff confirmed the laboratory did not perform testing personnel competency evaluations in 2018.