Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	05D0713931	11/14/2025
Name of Provider or Supplier	**Street Address, City, State**	
Av Dermatology & Surgery Center	44215 15th St W Ste 309, Lancaster, CA	

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
D5203	SPECIMEN IDENTIFICATION AND INTEGRITY CFR(s): 493.1232 The laboratory must establish and follow written policies and procedures that ensure positive identification and optimum integrity of a patient's specimen from the time of collection or receipt of the specimen through completion of testing and reporting of results. This STANDARD is not met as evidenced by: Based on the surveyor's review of patient testing records, log sheet, final reports, and an interview with the office manager (OM) on November 14, 2025; it was determined that the laboratory failed to follow established policies and procedures to ensure positive identification and optimum integrity of a patient's specimen from the time of collection or receipt of the specimen through completion of testing and reporting of results. The findings include: 1. The surveyor reviewed five patient records for Dermatopathology and identified one discrepancy. The last name of Patient 103125-10 varied across all records, such as the patient log sheet, Mohs map card, slides, and electronic chart. 2. No corrective action or amendment report was available for review at the time of survey. 3. The OM affirmed by an interview on November 14, 2025, at approximately 11:45 a.m. that records were discrepant in several records as mentioned in statement #1. 4. The laboratory's testing volume declaration submitted at the time of survey stated that 720 Dermatopathology tests were performed and reported annually including the time when the discrepancies occurred.
D5407	PROCEDURE MANUAL CFR(s): 493.1251(d) (d) Procedures and changes in procedures must be approved, signed, and dated by the current laboratory director before use.

	This STANDARD is not met as evidenced by: Based on the interview with the office manager (OM), review of the laboratory's policies and procedures, and document control on November 14, 2025; it was determined that the laboratory failed to follow an established policy and procedure that was approved, signed, and dated by the current laboratory director. The findings include: 1. The laboratory's review policy is for the current laboratory director to review and sign the document control for all policies and procedures annually wherein: a. Histopathology document control was last signed on 8/14/2019. b. Mohs document control lacked an established, approved, and/or review date. 2. On November 14, 2025, at approximately 10:40 a.m., the OM affirmed by an interview that the all of the document control pages for each policy and procedure for the laboratory operations and testing were not approved, signed, and/or dated by the current laboratory director. 3. The testing declaration form (Lab-144) submitted at the time of survey showed that the laboratory performed and reported approximately 720 patient samples for Dermatopathology during the time when policies and procedures were not approved, signed, and/or dated by the current laboratory director.
D6082	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(1) (e) The laboratory director must-- (e)(1) Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing; This STANDARD is not met as evidenced by: Based on the review of laboratory's policies and procedures, lack of corrective action reports for the errors found during patient review and an interview with the office manager on November 14, 2025, the laboratory director is herein cited for failure to provide quality laboratory services for all aspects of testing especially in the analytic and postanalytic phases of testing. The findings include: 1. One out of five patient records reviewed had a mismatch in the patient's last name across all records and lacked a corrective action report. See D5203. 2. The laboratory director failed to approved, signed, and/or dated the document control page of each policy and procedure annually. See D5407.