

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 05D2115541	(X3) Date Survey Completed 12/09/2021
Name of Provider or Supplier Precision Dermatology Inc	Street Address, City, State 770 Tamalpias Dr Ste 403, Corte Madera, 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
D5217	<p>EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1)</p> <p>At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part.</p> <p>This STANDARD is not met as evidenced by: Based on the surveyor's review of the laboratory's records for evaluation of proficiency testing performance and an interview with laboratory personnel (LP) on 12/9/2021 between 9 a.m. and 10 a.m., it was determined that the laboratory failed to at least twice annually, document their quality assurance/proficiency peer review testing for the year 2020. Findings include: 1. On 12/9/21, an inspection was conducted between 9 a.m. and 10 a.m. 2. During a review of the laboratory quality documentation, it was noted at approximately 9:30 a.m. that the laboratory failed to document peer proficiency testing for MOHS/ Histopathology in 2020. 3 The LP recognized that this documentation was missing. 4. MD peer review documentation was present for 2021.</p>
D5791	<p>ANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1289(a)(c)</p> <p>(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 analytic systems specified in 493.1251 through 493.1283. (c) The laboratory must document all analytic systems assessment activities.</p> <p>This STANDARD is not met as evidenced by: Based on the surveyor's review of the laboratory's records for internal documentation and an interview with laboratory personnel (LP) on 12/9/2021 between 9 a.m. and 10</p>

a.m., it was determined during a patient documentation audit that there was a date inconsistency between the internal MOHS operative map and the final pathology report for one patient. Findings include: 1. On 12/9/21, an inspection was conducted between 9 a.m. and 10 a.m. 2. During a review of the patient audit for 5 records , it was noted at approximately 9:40 a.m. that there was a documentation inconsistency for 1 of the 5 patients audited - One patient had a date of 9/1/21 on the slide and the visit note operative report, and the date on the Mohs Surgery Operative Map was 8/25 /21. 3. The LP recognized that this variance.