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| <b>Statement of Deficiencies</b>   | <b>(X1) Provider/Supplier/CLIA Identification Number</b><br><br>16D0913344                 | <b>(X3) Date Survey Completed</b><br><br>04/24/2018 |
| <b>Name of Provider or Supplier</b><br><br>Forefront Dermatology, Sc   | <b>Street Address, City, State</b><br><br>1225 South Gear Ave Ste 252, West Burlington, IA |   |
| For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency. |  |   |

| <b>(X4) ID Prefix Tag</b> | <b>Summary Statement of Deficiencies</b>   |
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| <b>D3027</b>              | <p><b>RETENTION REQUIREMENTS</b><br/>CFR(s): 493.1105(a)(1)</p> <p>Test requisitions and authorizations. Retain records of test requisitions and test authorizations, including the patient's chart or medical record if used as the test requisition or authorization, for at least 2 years.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on review of laboratory testing logs, the laboratory's electronic health record (EHR), and confirmed by the laboratory's histotechnologist at approximately 10:30 am on 04/24/2018, the laboratory failed to retain records of dermatophyte culture requisitions and authorizations for one out of three patients (Patient identifier C). The findings include: 1. According to the laboratory's histotechnologist, the providers use a form called "Laboratory Test Requisition and Report Form" to request performance of dermatophyte cultures and record final culture results. The form is given to clerical staff to be scanned into the EHR after final culture results are recorded. The form is discarded once it has been scanned into the EHR. 2. Patient identifier A had a dermatophyte culture performed on 08/29/2017 and finalized on 09/12/2017. 3. Patient identifier B had a dermatophyte culture performed on 08/11/2017 and finalized on 08/25/2017. 4. Patient identifier C had a dermatophyte culture performed on 08/10/2017 and finalized on 08/30/2017. 5. Review of EHR records revealed that the Laboratory Test Requisition and Report Form had been scanned for patient identifiers A and B, but not patient identifier C. 6. At the time of the survey, the laboratory's histotechnologist confirmed that the form had not been scanned into the EHR for patient identifier C and was not available in paper form.</p> |
| <b>D3041</b>              | <p><b>RETENTION REQUIREMENTS</b><br/>CFR(s): 493.1105(a)(6)</p> <p>Test reports. Retain or be able to retrieve a copy of the original report (including final,</p>   |

preliminary, and corrected reports) at least 2 years after the date of reporting. (i) In addition, retain immunohematology reports as specified in 21 CFR 606.160(d) (ii) and pathology test reports for at least 10 years after the date of reporting.

This STANDARD is not met as evidenced by:

Based on review of laboratory testing logs, the laboratory's electronic health record (EHR), and confirmed by the laboratory's histotechnologist at approximately 10:30 am on 04/24/2018, the laboratory failed to retain dermatophyte culture test reports for one out of three patients (Patient identifier C). The findings include: 1. According to the laboratory's histotechnologist, the providers use a form called "Laboratory Test Requisition and Report Form" as both a requisition to request performance of dermatophyte cultures and a test report where final culture results are recorded. The form is given to clerical staff to be scanned into the EHR after final culture results are recorded. The form is discarded once it has been scanned into the EHR. 2. Patient identifier A had a dermatophyte culture performed on 08/29/2017 and finalized on 09/12/2017. 3. Patient identifier B had a dermatophyte culture performed on 08/11/2017 and finalized on 08/25/2017. 4. Patient identifier C had a dermatophyte culture performed on 08/10/2017 and finalized on 08/30/2017. 5. Review of EHR records revealed that the Laboratory Test Requisition and Report Form had been scanned for patient identifiers A and B, but not patient identifier C. 6. At the time of the survey, the laboratory's histotechnologist confirmed that the test report had not been scanned into the EHR for patient identifier C and was not available in paper form.