

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  21D1072920	<b>(X3) Date Survey Completed</b>  01/06/2022
<b>Name of Provider or Supplier</b>  Advanced Dermatology Of Maryland	<b>Street Address, City, State</b>  3445-E Box Hill Corporate Center Dr, Abingdon, MD	
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>
<b>D5203</b>	<p><b>SPECIMEN IDENTIFICATION AND INTEGRITY</b> CFR(s): 493.1232</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on surveyor observation, record review, and interview with the laboratory director (LD), the laboratory did not 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. Findings: 1. During the survey, a patient specimen (patient #1, case # 20M516) was chosen in order to track it through the pre-analytical, analytical, and post-analytical stages of Mohs testing. While locating the stained slides for review, the histotech found a second set of slides for patient #1. It was observed that these slides were labeled with a different case number (# 20M515). 2. Review of the "Advanced Dermatology Mohs Log" showed that another patient (patient #2) was listed under case # 20M515. Further observation showed that the laboratory had slides for patient #2 which were also labeled with case # 20M515. The information on these slides matched the documentation on the "Advanced Dermatology Mohs Log" for patient #2. 3. During the survey at 11:00 AM on 1/6/2022 the LD performed an investigation and determined that the second set of slides for patient #1 was labeled with the wrong case number. The LD confirmed that the laboratory did not follow procedures to ensure positive identification of patient specimens through each step of testing.</p>