

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 29D0687906	(X3) Date Survey Completed 04/09/2018
Name of Provider or Supplier Las Vegas Skin And Cancer Clinics-Pecos	Street Address, City, State 4488 S Pecos Rd, Las Vegas, NV	
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
D0000	This Statement of Deficiencies was created as a result of an on-site CLIA recertification survey conducted at your facility on April 9, 2018. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.
D5209	<p>PERSONNEL COMPETENCY ASSESSMENT POLICIES CFR(s): 493.1235</p> <p>As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency.</p> <p>This STANDARD is not met as evidenced by: Based on a review of testing personnel competency records for the time period between 4/25/16 and 4/09/18 in the testing category of histopathology and an interview with the laboratory compliance officer, the laboratory failed to follow the director approved laboratory policy to assess and document patient testing personnel competency at least twice annually in the testing category of histopathology. Findings include: There was no documentation of twice a year verification of accuracy competency for one of one testing personnel in the testing category of histopathology for testing year 2017. This was confirmed by the laboratory compliance officer on April 9, 2018 at approximately 9:30 AM. The laboratory performs approximately 527 patient histopathology tests annually.</p>
D5401	<p>PROCEDURE MANUAL CFR(s): 493.1251(a)</p> <p>A written procedures manual for all tests, assays, and examinations performed by the</p>

laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory's written procedures for testing or examining specimens.

This STANDARD is not met as evidenced by:
Based on a review of the director approved laboratory policy and procedure manual which addresses instrument maintenance and an interview with the laboratory compliance officer, the laboratory failed to follow the established laboratory policy for the maintenance interval for microscopes. Findings include: 1. The laboratory failed to follow the established laboratory policy for the maintenance of microscopes to read histopathology slides of having scheduled maintenance performed every six months. 2. The laboratory had documentation of microscope maintenance performed annually. This was confirmed by the laboratory compliance officer on April 9, 2018 at approximately 10:00 AM. The laboratory performs approximately 527 patient histopathology tests annually.

D6021

LABORATORY DIRECTOR RESPONSIBILITIES
CFR(s): 493.1407(e)(5)

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)(5) Ensure that quality assessment programs are established and maintained to assure the quality of laboratory services provided.

This STANDARD is not met as evidenced by:
Based on a review of the director approved laboratory policy and procedure manual which covers quality assessment, a review of the laboratory quality assessment documentation for testing years 2016 and 2017 and an interview with the laboratory compliance officer, the director failed to follow the established policy for laboratory quality assessment to assure the quality of the laboratory services provided. Findings include: 1. The laboratory director failed to follow the established policy to have monthly quality assessment of patient laboratory services provided to determine the quality of the laboratory services. 2. The laboratory had no documentation monthly quality assessment for testing year 2016 and documentation of quality assessment for October, November and December for testing year 2017. This was confirmed by the laboratory compliance officer on April 9, 2018 at approximately 10:30 AM. The laboratory performs approximately 527 patient histopathology tests annually.