Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	29D0965583	07/25/2023
Name of Provider or Supplier	**Street Address, City, State**	
Nevada Center For Dermatology	650 Sierra Rose Dr Ste A, Reno, 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 July 25, 2023. 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.
D5217	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1) 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. This STANDARD is not met as evidenced by: Based on review of the internal and external slide reviews performed as accuracy checks, the laboratory policies and procedures, and an interview with the office manager and laboratory director, the laboratory failed to ensure that twice a year accuracy checks were performed. Findings include: 1. A review of the internal and external slide reviews performed during 2022 and 2023 revealed that slides for one case of Mohs surgery had been sent to the American Society for Mohs Surgery for evaluation during 2022. There were no additional Mohs cases that were reviewed in order to complete the required twice per year accuracy check during 2022. 2. The laboratory procedure, "Quality Control," indicates that the laboratory is to participate in the American Society of Moh's Surgery Peer Review at least once a year. Additionally, one Moh's case is to be reviewed internally by a second provider to ensure accuracy. 3. An interview with the office manager and the laboratory director on July 25, 2023 at approximately 11:00 AM confirmed these findings. The laboratory performs approximately 350 histopathology tests annually.
D5413	TEST SYSTEMS, EQUIPMENT, INSTRUMENTS, REAGENT

	CFR(s): 493.1252(b) The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (1) Water quality. (2) Temperature. (3) Humidity. (4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This STANDARD is not met as evidenced by: Based on review of room, refrigerator, and cryostat temperature logs, and an interview with the office manager, the laboratory failed to ensure that the acceptable ranges for room, refrigerator, and cryostat temperatures were documented on the log sheets for each month. Findings include: 1. A review of room, refrigerator, and cryostat temperature logs from January 2022 through July 2023 revealed that the acceptable temperature ranges were not included on the log sheets from March 2023 through July 2023, therefore recorded temperatures could not be compared to the acceptable ranges. 2. An interview with the office manager on July 25, 2023, at approximately 10: 30 AM confirmed these findings. The laboratory performs approximately 70 microbiology and 350 histopathology tests annually.
D5891	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(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 postanalytic systems specified in 493.1291. This STANDARD is not met as evidenced by: Based on a review of the laboratory policies and procedures and an interview with the office manager and the laboratory director, the laboratory failed to ensure that a written Quality Assurance (QA) procedure was established to identify and correct deficiencies in quality. Findings include: 1. A review of the laboratory's policies and procedures revealed that there was no documented QA policy and procedure for the laboratory staff to follow in order to identify and correct deficiencies in quality. 2. These findings were confirmed in an interview with the office manger and the laboratory director on July 25, 2023, at approximately 11:00 AM. The laboratory performs approximately 70 microbiology and 350 histopathology tests annually.