Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	29D1065370	10/02/2024
Name of Provider or Supplier	**Street Address, City, State**	
Pahrump Dermatology & Skin Cancer	1470 E Calvada Blvd Suite #600, Pahrump, 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 October 2, 2024. 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.
D5200	GENERAL LABORATORY SYSTEMS CFR(s): 493.1230 Each laboratory that performs nonwaived testing must meet the applicable general laboratory systems requirements in 493.1231 through 493.1236, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the general laboratory systems and correct identified problems specified in 493.1239 for each specialty and subspecialty of testing performed. This CONDITION is not met as evidenced by: Based on the number and severity of the deficiency cited herein, the Condition: General Laboratory Systems was not met. The laboratory failed to follow established director approved policies and procedures to maintain optimal specimen integrity from collection of the specimen through testing and final reporting of results. (refer to Tag D5203)
D5203	SPECIMEN IDENTIFICATION AND INTEGRITY CFR(s): 493.1232 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.

This STANDARD is not met as evidenced by:
Based on a review of the director approved policy entitled, "Policy & Procedure Quality Assurance", a review of the director approved policy entitled, "Post Analytical Mohs Audit", a review of the laboratory Post Analytical Mohs audit records between the dates of May 7, 2024 and September 24, 2024, a random audit of Mohs patients tested between the dates of May 9, 2023 and September 10, 2024, and an interview with the office manager, the laboratory failed to ensure that the written policies and procedures were followed to ensure positive identification and optimum integrity of patient specimens was maintained from the time of collection through the completion of testing and reporting of results. Findings include: 1. The director approved policy entitled, "Policy & Procedure Quality Assurance", in the section entitled, "Quality Assurance Procedures During Mohs" stated, "The patient's name is written on the slide, as well as the patients (sic) date of birth, surgery site, surgery date, stage of surgery, and biopsy specimen number." 2. The director approved policy entitled, "Post Analytical Mohs Audit" stated, "The office manager is responsible for verifying the MOHS (sic) map card, MOHS (sic) log, patient electronic record, MOHS (sic) technician log and slides." The policy later stated, "The information that will be checked will be the patient's name, date of birth, diagnosis of lesion treated, site of lesion treated, patient identification number (biopsy accession number & letter), facility name and address and the electronic signature of the board certified dermatologist who performed the procedure. The manager will then print off one patient's finalized chart note, Mohs map card, and take a copy of the patient's slides. This will then be placed behind the Mohs date of service for District Manager auditing purposes. If there are any discrepancies in any of the above named patient information, there will be corrective action taken by the office manager who is auditing the patient information." 3. A review of the laboratory Post-Analytical Mohs Audit records performed each day of Mohs testing between the dates of May 7, 2024 and September 24, 2024 revealed that the laboratory failed to detect and correct the failure to follow the director approved procedure for the labeling of patient slides to include the patient's name, the patient's date of birth, surgery site, surgery date, stage of surgery, and biopsy specimen number as follows: A. The slides for the patient record, case number Z24-0183C, dated May 7, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. B. The slides for the patient record, case number GD243008564C, dated May 21, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. C. The stage I slide for the patient record, case number Z24-0314A, dated June 4, 2024 that was audited by the lab did not include the biopsy accession number. The stage II slide did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. D. The slides for the patient record, case number GD243011258A, dated June 18, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. E. The slides for the patient record, case number GD243015834A, dated July 2, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. F. The slides for the patient record, case number Z24-0382B, dated July 16, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. G. The slides for the patient record, case number Z24-0353A, dated July 30, 2024 that were audited by the lab did not include the patient date of

	birth, or the biopsy accession number. There was no documentation of corrective action. H. The slides for the patient record, case number Z24-0458A, dated August 13, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. I. The slides for the patient record, case number GD24015829B, dated August 27, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. J. The slides for the patient record, case number GD223017594A, dated September 10, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. K. The slides for the patient record, case number GD243022741A, dated September 24, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. The slides also did not include the correct site of the lesion treated. The slides were labeled as "R jaw angle". The actual site of the lesion treated was the right lateral frontal scalp. There was no documentation of corrective action. 4. A random audit of Mohs patients tested between the dates of May 9, 2023 and September 10, 2024 revealed that slides for three of six patients were not labeled in accordance with the director approved slide labeling policy, as follows: A. The stage II slide for the patient record, case number Z23-0829B, dated December 19, 2023 audited at the time of the survey did not include the patient date of birth. B. The slides for the patient record, case number Z24-0375A, dated July 2, 2024 audited at the time of the survey did not include the patient date of birth. C. The slides for the patient record, case number Z24-0555B, dated September 10, 2024 audited at the time of the survey did not include the patient date of birth or the biopsy accession number. 5. The findings were confirmed during an interview with the office manager conducted on October 2, 2024 at approximately 11:30 AM. This deficiency was cited at the time of the previous CLIA surveys dated June 14, 2021 and February 27, 2023. The laboratory performs approximately 1000 histopathology tests annually.
D6076	LABORATORY DIRECTOR CFR(s): 493.1441 The laboratory must have a director who meets the qualification requirements of 493. 1443 of this subpart and provides overall management and direction in accordance with 493.1445 of this subpart. This CONDITION is not met as evidenced by: Based on the number and severity of the deficiency cited herein, the Condition: Laboratories Performing High Complexity Testing; Laboratory Director, was not met. The director failed to ensure that the director approved established quality assessment program to detect and correct failures in quality was maintained. (refer to Tag D6094)
D6094	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) The laboratory director must ensure that the quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur. This STANDARD is not met as evidenced by: Based on a review of the director approved policy entitled, "Policy & Procedure

Quality Assurance", a review of the director approved policy entitled, "Post Analytical Mohs Audit", a review of the laboratory Post Analytical Mohs audit records between the dates of May 7, 2024 and September 24, 2024, and an interview with the office manager, the director failed to ensure that the written quality assurance policies were followed to detect and correct failures in quality when they occurred. Findings include: 1. The director approved policy entitled, "Policy & Procedure Quality Assurance", in the section entitled, "Quality Assurance Procedures During Mohs" stated, "The patient's name is written on the slide, as well as the patients (sic) date of birth, surgery site, surgery date, stage of surgery, and biopsy specimen number." 2. The director approved policy entitled, "Post Analytical Mohs Audit" stated, "The office manager is responsible for verifying the MOHS (sic) map card, MOHS (sic) log, patient electronic record, MOHS (sic) technician log and slides." The policy later stated, "The information that will be checked will be the patient's name, date of birth, diagnosis of lesion treated, site of lesion treated, patient identification number (biopsy accession number & letter), facility name and address and the electronic signature of the board certified dermatologist who performed the procedure. The manager will then print off one patient's finalized chart note, Mohs map card, and take a copy of the patient's slides. This will then be placed behind the Mohs date of service for District Manager auditing purposes. If there are any discrepancies in any of the above named patient information, there will be corrective action taken by the office manager who is auditing the patient information." 3. A review of the laboratory Post-Analytical Mohs Audit records performed each day of Mohs testing between the dates of May 7, 2024 and September 24, 2024 revealed that the laboratory failed to detect and correct the failure to follow the director approved procedure for the labeling of patient slides to include the patient's name, the patient's date of birth, surgery site, surgery date, stage of surgery, and biopsy specimen number as follows: A. The slides for the patient record, case number Z24-0183C, dated May 7, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. B. The slides for the patient record, case number GD243008564C, dated May 21, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. C. The stage I slide for the patient record, case number Z24-0314A, dated June 4, 2024 that was audited by the lab did not include the biopsy accession number. The stage II slide did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. D. The slides for the patient record, case number GD243011258A, dated June 18, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. E. The slides for the patient record, case number GD243015834A, dated July 2, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. F. The slides for the patient record, case number Z24-0382B, dated July 16, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. G. The slides for the patient record, case number Z24-0353A, dated July 30, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. H. The slides for the patient record, case number Z24-0458A, dated August 13, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. I. The slides for the patient record, case number GD24015829B, dated August 27, 2024 that were audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. J. The slides for the patient record, case number GD223017594A, dated September 10, 2024 that were

	audited by the lab did not include the patient date of birth, or the biopsy accession number. There was no documentation of corrective action. 4. The findings were confirmed during an interview with the office manager conducted on October 2, 2024 at approximately 11:30 AM. This deficiency was cited at the time of the previous CLIA surveys dated June 14, 2021 and February 27, 2023. The laboratory performs approximately 1000 histopathology tests annually.