Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 29D1096978	(X3) Date Survey Completed 08/09/2021
Name of Provider or Supplier Las Vegas Dermatology And Skin Cancer	**Street Address, City, State** 5731 S Fort Apache Road, Ste 130, 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 August 9, 2021. 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.
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 random patient audit between the dates of May 13, 2019 and June 21, 2021, and an interview with the Laboratory Regional Manager, the laboratory failed to ensure that the established policy and procedures were followed to maintain the positive identification of the patient specimen from the time of collection of the specimen through the reporting of the test results. Findings include: 1. A random patient audit between the dates of May 13, 2019 and June 21, 2021 revealed that the Mohs Patient Identification Number was not consistent on the patient Mohs logs, the Mohs slides, the Mohs map, and the final operative notes for three of eight patient records reviewed. 2. The patient record reviewed for October 8, 2019 revealed that the Mohs Patient Identification Number on the Mohs log, and in the patient final operative report was listed as L19-0702A. The Mohs Patient Identification Number written on the Mohs Map, and the Mohs slides had been changed from L19-0702A to L20-150A. The date of the biopsy written on the Mohs Map was changed from the date of September 5, 2019 to the date of March 31, 2021. An interview with the

	Laboratory Regional Manager on August 9, 2021 at approximately 11:15 AM confirmed that the Mohs Patient Identification numbers on the slides and the Mohs map were changed, but could not specify when the changes were made. 3. The patient record reviewed for March 30, 2020 revealed that the Mohs Patient Identification Number on the Mohs log, and the Mohs slides was listed as SP20-661A. On the Mohs Map and in the final operative report, the Mohs Patient Identification number was listed as SP20-661B. The Laboratory Regional Manager confirmed the findings during an interview conducted on August 9, 2021 at approximately 11:15 AM. 4. The patient record reviewed for March 1, 2021 revealed that the Mohs log did not include the Mohs Patient Identification Number. The Mohs Patient Identification number was listed on the Mohs map, the Mohs slides, and the final operative report as L21-0039A. Further review of the March 1, 2021 log revealed that the Mohs Patient Identification number was not included on the log for 11 of 11 patients tested on that day. The Laboratory Regional Manager confirmed the findings during an interview conducted on August 9, 2021 at approximately 11:15 AM. The laboratory performs approximately 360 histopathology tests annually.
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 and procedure entitled, "Post-Analytical Mohs Audit," a random patient audit between the dates of May 13, 2019 and June 21, 2021, a review of the laboratory quality assessment documentation, and an interview with the Regional Laboratory Manager, the director failed to ensure that the quality assessment policy and procedure was followed to detect and correct errors in the maintenance of the specimen identity through the pre-analytical, analytical, and post-analytical phases of Mohs testing. Findings include: 1. The director approved policy and procedure entitled, "Post Analytical Mohs Audit" stated, "At the end of each Mohs, there will be an audit performed by the office manager. The office manager will be responsible for verifying the Mohs map card, Mohs log, patient electronic record, Mohs technician log and slides. This is to ensure that the information that is input on all these records is correct and true. 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 accesson number & letter)." The Regional Laboratory Manager stated that the laboratory reviews one patient record on each day of Mohs testing for accuracy during an interview conducted on August 9, 2021 at approximately 11:00 AM. 2. A random patient audit between the dates of May 13, 2019 and June 21, 2021 revealed that the established quality assessment procedure was not followed and failed to detect and correct discrepancies in the Mohs Patient Identification numbers for three of eight patient records reviewed. 3. The patient record reviewed for October 8, 2019 revealed that changes were made to the Mohs Patient Identification Number on the Mohs slides and the Mohs map, and the biopsy date on the Mohs map, when the original Mohs Patient Identification Number, L19-0702A, and biopsy date, September 5, 2019, were correct. 3. There was no documentation of quality assessment and corrective action for the discrepancy revealed in the patient audit review for March 30, 2020. The patient audit revealed that the Mohs Patient Identification Number on the Mohs log, and the Mohs

	slides did not match the identification number on the Mohs map and in the final operative report. The number on the Mohs log and Mohs slides was SP20-661A. On the Mohs Map and in the final operative report, the Mohs Patient Identification number was SP20-661B. 4. There was no documentation of corrective action in the quality assessment record for the omission of the Patient Identification Number on the Mohs log used on on March 1, 2021 for 11 of 11 patients tested. The quality assessment documentation for March 1, 2021 revealed that one patient of the day was reviewed by the Office Manager and the Regional Laboratory Manager. 5. The Laboratory Regional Manager confirmed the findings during an interview conducted on August 9, 2021 at approximately 11:15 AM. The laboratory performs approximately 360 histopathology tests annually.