| **Statement of Deficiencies** | **(X1) Provider/Supplier/CLIA Identification Number** | **(X3) Date Survey Completed** |
|---|---|---|
| | 29D1096978 | 05/31/2023 |
| **Name of Provider or Supplier** | **Street Address, City, State** | |
| Las Vegas Dermatology And Skin Cancer | 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 |
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| **D0000** | This Statement of Deficiencies was created as a result of an on-site CLIA recertification survey conducted at your facility on May 31, 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. |
| **D6094** | LABORATORY DIRECTOR RESPONSIBILITIES<br>CFR(s): 493.1445(e)(5)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on a review of the monthly quality assessment records between the dates of August, 2021 and May, 2023, a review of the director procedure entitled, "Post Analytical Mohs Audit", and an interview with the laboratory personnel, the director failed to ensure that the established quality assessment program was maintained to detect and correct errors in laboratory service when they occurred. Findings include: 1. A review of the monthly quality assessment records between the dates of August, 2021 and May, 2023 revealed that the laboratory failed to detect and correct errors when they occurred. 2. The quality assessment review for January 17, 2022 revealed that there was no corrective action taken for the failure to include the patient identification number, LV237974QD, on the Mohs slide for the patient reviewed. 3. The quality assessment review for March 31, 2022 revealed that there was no copy of the slides and the Mohs map that were reviewed in the quality assessment records for patient identification number LV744515Q. 4. The quality assessment review for April 28, 2022 revealed that there was no corrective action taken for the discrepancy between the number of slides listed on the log, and the number of slides copied for |

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| | review for patient identification number L22-0038. The Mohs log stated that there were two slides for the patient. The copy of the Mohs map and the Mohs slide included one slide. 5. The quality assessment review for May 26, 2022 revealed that there was no corrective action taken for the failure to include patient identification numbers on the Mohs log for 14 of 14 patients. There was also no corrective action taken for the failure to include the patient identification number on the slide for the patient identified by the initials ET whose records were reviewed for quality assessment. 6. The quality assessment review for March 30, 2023 revealed that there was no corrective action taken for the discrepancies between the Mohs log, the Mohs map and the operative note indicating the date of the biopsy, the patient ID, and the operative site, and there was no copy of the Mohs slides in the quality assessment records. On the Mohs log, it stated that the patient, MH, had a biopsy date of 2/16/23. The patient ID on the log was L23-0074B. The site of the Mohs surgery indicated on the log was the Left Anterior Parietal Scalp. On the Mohs map, and in the operative note, it stated that the patient biopsy date was 3/30/23, there was no patient identification number, and the site was listed was Left Medial Inferior Chest. The biopsy report included in the quality assessment review was dated 11/4/22, with a patient identification number of L22-0459, and site for specimen A of Left Medial Chest. 7. A review of the director approved policy entitled, "Post-Analytical Mohs Audit" stated, "The office manager will be responsible for verifying the MOHS (sic) map car, MOHS (sic) log, patient electronic record, MOHS (sic) technician log and slides...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 and letter), facility name and address and the electronic signature of the board certified dermatologist who performed the procedure." The policy goes on to state, "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." 8. The findings were confirmed during an interview conducted with the laboratory manager conducted on May 31, 2023 at approximately 3:15 PM. The laboratory performs approximately 360 histopathology procedures annually. |