| **Statement of Deficiencies** | **(X1) Provider/Supplier/CLIA Identification Number** | **(X3) Date Survey Completed** |
|---|---|---|
| | 29D2017786 | 12/19/2024 |
| **Name of Provider or Supplier** | **Street Address, City, State** | |
| Las Vegas Skin & Cancer Clinics-Centennial Hills | 9780 W Skye Canyon Park Dr Ste 100, 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 December 19, 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. |
| **D5403** | PROCEDURE MANUAL<br>CFR(s): 493.1251(b)<br><br>The procedure manual must include the following when applicable to the test procedure: (1) Requirements for patient preparation; specimen collection, labeling, storage, preservation, transportation, processing, and referral; and criteria for specimen acceptability and rejection as described in 493.1242. (2) Microscopic examination, including the detection of inadequately prepared slides. (3) Step-by-step performance of the procedure, including test calculations and interpretation of results. (4) Preparation of slides, solutions, calibrators, controls, reagents, stains, and other materials used in testing. (5) Calibration and calibration verification procedures. (6) The reportable range for test results for the test system as established or verified in 493.1253. (7) Control procedures. (8) Corrective action to take when calibration or control results fail to meet the laboratory's criteria for acceptability. (9) Limitations in the test methodology, including interfering substances. (10) Reference intervals (normal values). (11) Imminently life-threatening test results, or panic or alert values. (12) Pertinent literature references. (13) The laboratory's system for entering results in the patient record and reporting patient results including, when appropriate, the protocol for reporting imminently life threatening results, or panic, or alert values. (14) Description of the course of action to take if a test system becomes inoperable.<br><br>This STANDARD is not met as evidenced by: |

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| | Based on a random patient audit between the dates of December 3, 2022 and December 18, 2024, a review of the laboratory policy and procedure manual, and an interview with the Director of Regulatory Compliance, the laboratory failed to ensure that the available procedure manual included a procedure for the performance and documentation of the Hematoxylin and Eosin (H&E) Stain quality control for Mohs testing. Findings include: 1. A random patient audit between the dates of December 3, 2022 and December 18, 2024 revealed that there was no documentation of the H&E stain quality available for December 18, 2024. 2. A review of the laboratory procedure manual revealed that there was no director approved procedure for the documentation of the H&E stain quality for Mohs testing. 3. The Director of Regulatory Compliance confirmed the findings during an interview conducted on December 19, 2024 at approximately 12:15 PM. The laboratory performs approximately 250 Histopathology tests annually. |
| **D5473** | CONTROL PROCEDURES<br>CFR(s): 493.1256(e)(2)(g)<br><br>(e) For reagent, media, and supply checks, the laboratory must do the following: (e) (2) Each day of use (unless otherwise specified in this subpart), test staining materials for intended reactivity to ensure predictable staining characteristics. Control materials for both positive and negative reactivity must be included, as appropriate. (g) The laboratory must document all control procedures performed.<br><br>This STANDARD is not met as evidenced by:<br>Based on a random patient audit between the dates of December 3, 2022 and December 18, 2024 and an interview with the Director of Regulatory Compliance, the laboratory failed to ensure that the Hematoxylin and Eosin (H&E) Stain quality control for Mohs testing was read and documented each day of use. Findings include: 1. A random patient audit between the dates of December 3, 2022 and December 18, 2024 revealed that there was no documentation of the H&E stain quality control available for the date of December 18, 2024. 2. The Director of Regulatory Compliance confirmed the findings during an interview conducted on December 19, 2024 at approximately 12:15 PM. The laboratory performs approximately 250 Histopathology tests annually. |