Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	29D2044597	02/22/2024
Name of Provider or Supplier	**Street Address, City, State**	
Centennial Dermatology & Skin Center	5550 Painted Mirage Rd Ste 200, 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 February 22, 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.
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 laboratory quality assessment records, a random patient audit of seven patients tested between the dates of July 20, 2022 and February 13, 2024, a review of the laboratory quality assessment and slide labeling procedures and an interview with the corporate manager on February 22, 2024 between approximately 2: 00 PM and 3:30 PM, the laboratory failed to ensure that specimen identification and integrity were maintained from collection of the specimen through the reporting of the results. Findings include: 1. A review of the laboratory quality assessment records between the months of May, 2022 and January, 2024 revealed that the specimen accession numbers were not written on the slide labels for eight of eight patients on the date of September 13, 2023, and the specimen accession numbers were not written on the slide labels for nine of nine patients on the date of October 11, 2023. 2. The laboratory failed to follow the director approved policy for slide labeling. The laboratory policy entitled "Policy & Procedure Quality Assurance," in the section entitled, "Quality Assurance Procedures During Mohs" stated, "The patients name is

	written on the slide, as well as the patient's date of birth, surgery site, surgery date, site of surgery and biopsy specimen number." 3. A random patient audit of seven patients tested between the dates of July 20, 2022 and February 13, 2024 revealed that the specimen accession number and surgery site was not consistent on the biopsy report, Mohs log, the Mohs map, the Mohs slides, and the final operative report for a Mohs patient tested on October 25, 2022. The Mohs log indicated that the operative site for the patient, accession number DAC22-299400C, was the right clavicle. The Mohs map, Mohs slides and final operative report indicated that the operative site was the left lateral upper arm. The accession number generated based on the biopsy report was not consistent with the laboratory policy for the operative site of the left lateral upper arm. The laboratory policy states that the accession number is generated from the pathology laboratory's biopsy report accession number and a letter corresponding with the particular tissue biopsy site. According to the biopsy report, DAC22-299400C corresponds with specimen C on the biopsy report, designated at the right clavicle. The left lateral upper arm was identified as specimen B on the biopsy report. 4. The laboratory failed to follow the director approved policy for quality assessment. The laboratory quality assessment policy entitled, "Post Analytical Mohs Audit" stated, "The office manager will be responsible for verifying the MOHS map card, Mohs log, patient electronic record, Mohs technician log and slides." The policy further stated, "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." 5. The findings were confirmed during an interview with the corporate manager on on February 22, 2024 at approximately 3:30 PM. The laboratory performs approximately 300 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 laboratory quality assessment records, a random patient audit of seven patients tested between the dates of July 20, 2022 and February 13, 2024, a review of the laboratory quality assessment and slide labeling procedures and an interview with the corporate manager on February 22, 2024 between approximately 2: 00 PM and 3:30 PM, the laboratory failed to ensure that specimen identification and integrity were maintained from collection of the specimen through the reporting of the results. Findings include: 1. A review of the laboratory quality assessment records between the months of May, 2022 and January, 2024 revealed that the specimen accession numbers were not written on the slide labels for eight of eight patients on the date of September 13, 2023, and the specimen accession numbers were not written on the slide labels for nine of nine patients on the date of October 11, 2023 in accordance with the established laboratory procedure. 2. The director failed to ensure that the laboratory follwed the director approved slide labeling policy. The laboratory policy entitled "Policy & Procedure Quality Assurance," in the section entitled, "Quality Assurance Procedures During Mohs" stated, "The patients name is written on the slide, as well as the patient's date of birth, surgery site, surgery date, site of surgery and biopsy specimen number." 3. A random patient audit of seven patients tested between the dates of July 20, 2022 and February 13, 2024 revealed that the specimen accession number and surgery site was not consistent on the biopsy report,

	Mohs log, the Mohs map, the Mohs slides, and the final operative report for a Mohs patient tested on October 25, 2022. The Mohs log indicated that the operative site for the patient, accession number DAC22-299400C, was the right clavicle. The Mohs map, Mohs slides and final operative report indicated that the operative site was the left lateral upper arm. The accession number generated based on the biopsy report was not consistent with the laboratory policy for the operative site of the left lateral upper arm. The laboratory policy states that the accession number is generated from the pathology laboratory's biopsy report accession number and a letter corresponding with the particular tissue biopsy site. According to the biopsy report, DAC22-299400C corresponds with specimen C on the biopsy report, designated at the right clavicle. The left lateral upper arm was identified as specimen B on the biopsy report. 4. The director failed to ensure that the laboratory followed the director approved quality assessment policy. The laboratory quality assessment policy entitled, "Post Analytical Mohs Audit" stated, "The office manager will be responsible for verifying the MOHS map card, Mohs log, patient electronic record, Mohs technician log and slides." The policy further stated, "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." 5. The findings were confirmed during an interview with the corporate manager on on February 22, 2024 at approximately 3:30 PM. The laboratory performs approximately 300 histopathology tests annually.