

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 29D2164544	(X3) Date Survey Completed 08/19/2021
Name of Provider or Supplier Henderson Dermatology & Skin Cancer	Street Address, City, State 2960 St Rose Pkwy, Ste 120, Henderson, 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 19, 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.
D5217	<p>EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1)</p> <p>At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part.</p> <p>This STANDARD is not met as evidenced by: Based on a review of laboratory records of documentation of twice per year verification of accuracy, a review of the director approved policy entitled, "Proficiency Testing," and an interview with the Laboratory Regional Manager, the laboratory failed to ensure that the twice per year verification of accuracy was performed for one of two dermatologists performing Mohs testing during 2020. Findings include: 1. There was no documentation of the twice per year verification of accuracy during 2020 for one of two dermatologists performing Mohs procedures in the laboratory. 2. The director approved policy entitled "Proficiency Testing" stated, "Twice a year, an assigned medical assistant is to go through the patient surgery lists and randomly choose one patient to have the Mohs surgery slide(s) sent out to be reviewed by another Board Certified Dermatologist in our company to check the performing Doctor's accuracy." 3. The Laboratory Regional Manager confirmed the finding during an interview conducted on August 19, 2021 at approximately 12:45 PM. The laboratory performs approximately 360 histopathology tests annually.</p>
D5221	EVALUATION OF PROFICIENCY TESTING PERFORMANCE

CFR(s): 493.1236(d)

All proficiency testing evaluation and verification activities must be documented.

This STANDARD is not met as evidenced by:

Based on a review of the Mohs Surgery Proficiency Log documenting the twice per year verification of accuracy for the Mohs testing, a review of the Mohs review records, and an interview with the Laboratory Regional Manager, the laboratory recorded that the proficiency testing review for Mohs surgery dates May 10, 2021, June 7, 2021, July 12, 2021, and August 9, 2021 were in agreement prior to the Mohs cases selected for the twice per year verification of accuracy were sent to the reference laboratory for review. Findings include: 1. A review of the Mohs Surgery Proficiency Log for 2021 revealed that the twice per year verification of accuracy was documented as in agreement for the cases selected for review from the Mohs surgery dates of May 10, 2021, June 7, 2021, July 12, 2021, and August 9, 2021. 2. A review of the Mohs Surgery review records for the twice per year verification of accuracy revealed that the case reviews for the dates of May 10, 2021, June 7, 2021, July 12, 2021, and August 9, 2021 were not returned to the laboratory at the time of the survey. 3. The Laboratory Regional Manager stated that the slides and records for the cases selected from May 10, 2021, June 7, 2021, July 12, 2021, and August 9, 2021 had not been sent to the reference laboratory for the verification of accuracy at the time of the survey. The laboratory performs approximately 360 histopathology procedures 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 quality assessment documentation for the Mohs surgery date of February 17, 2020, and an interview with the Laboratory Regional Manager, the director failed to ensure that the established system of quality assurance was maintained to detect and correct errors in the maintenance of the patient records. Findings include: 1. The laboratory failed to identify the discrepancy between the number of slides listed on the Mohs surgery log, and the number of slides prepared and read by the dermatologist for the Mohs case number H20-0002A performed on February 17, 2020 during the quality assessment review. 2. The Mohs log stated that two slides were prepared for the February 17, 2020 Mohs case number H20-0002A. A photocopy of the Mohs slides and the Mohs map revealed that three slides were prepared. 3. The quality assessment documentation for February 17, 2020 revealed that the record had been reviewed by the Office Manager, and by the Regional Manager, but there was no documentation that the discrepancy was detected in the quality assessment review. 4. The Laboratory Regional Manager confirmed the finding during an interview on August 19, 2021 at approximately 12:45 PM. The laboratory performs approximately 360 histopathology procedures annually.