Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	38D0624734	10/17/2022
Name of Provider or Supplier	**Street Address, City, State**	
Dermatology Associates	10215 Sw Hall Blvd, Tigard, OR	

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
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 review of Histopathology records and interview with the Laboratory Director (LD) during survey 10/17/2022, the laboratory failed to document the dates and cases used to evaluate microscopic proficiency for the two (2) providers performing Mohs surgery and interpretation of the slides prepared during Mohs surgery. Findings include: 1. Upon review of the proficiency records for the two (2) Mohs surgeons performing Mohs surgery, there were no dates or case numbers documented to meet the bi-annual verification requirements required for unregulated analytes for 2021 or 2022. 2. The LD confirmed during interview on 10/17/2022 at approximately 12:00 pm that there was no written documentation of the dates and case numbers used to ensure Mohs slide interpretation provider proficiency bi-annually for 2021 and 2022. 3. This facility had zero (0) out of four (4) required bi-annual verification written documentation with case numbers and dates of assessment for the two (2) providers performing Mohs surgery for 2021 and 2022.
D5291	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and, when indicated, correct problems identified in the general laboratory systems requirements specified at 493.1231 through 493.1236. This STANDARD is not met as evidenced by:

	Based on review of the Quality Assurance (QA) policy/procedure adopted by this laboratory and interview with the Laboratory Director (LD) during survey 10/17 /2022, the laboratory failed to follow and document in writing their QA activities at least twice per year. Findings include: 1. Upon review of the QA procedure and discussion with the LD, the laboratory failed to follow the procedure with written activities / records as dictated by this procedure for the years 2021 and 2022. 2. Interview with the Histotechnician during survey at approximately 1100 am revealed that he was unaware of any written QA activities for the years 2021 and 2022. 3. Interview with the LD during survey at approximately 1:00 pm confirmed there was no written documentation of QA activities as listed in their QA procedure (#C numbers 1 - 7). 4. At least two monitoring events are required per year for QA. The laboratory had zero (0) out of four (4) QA activities documented in writing for 2021 and 2022.