

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 45D0934652	(X3) Date Survey Completed 04/11/2022
Name of Provider or Supplier Ameripath At Baylor Surgicare At North Dallas	Street Address, City, State 12230 Coit Road, Suite 200, Dallas, TX	
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	Laboratory representatives were present at the entrance conference. The survey process was discussed. An opportunity for questions and comments was given. The exit conference was held with the laboratory representatives. The laboratory was found to be in substantial compliance for the specialties/subspecialties for which it was surveyed. The standard level deficiencies cited were discussed. The process for submitting the corrections was explained. CMS form 2567 will be emailed from the Texas Health and Human Services Commission, Health Facility Compliance Arlington Group. Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Southern Operations Branch-Dallas for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.
D5203	<p>SPECIMEN IDENTIFICATION AND INTEGRITY CFR(s): 493.1232</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on review of laboratory policy, direct observation, specimen frozen section log, patient test requisitions, patient final test reports, and confirmed in interview, the laboratory failed to ensure positive identification and optimum integrity of patient specimens from the time of collection and receipt of the specimen through completion of testing and reporting of results for 1 of 6 patients reviewed. Findings included: 1. Review of the laboratory's policy titled "Positive Patient Identification for Anatomic</p>

Pathology-Histopathology Specimen(s)" effective date 11/14/2013, revealed the following: "1. PURPOSE This document provides guidelines 1) to establish an active process to ensure and verify confirmation of Positive Patient Identification at each step of the specimen work flow [sic] in Anatomic Pathology (Histopathology) - from specimen collection to reporting of results- and 2) to work towards the highest level of accuracy and patient safety on a daily basis ... 5. PROCEDURE Step Specimen Collection and Transportation Action Specimen Collection Manual/Directory of Services: Ensure documented procedures/directions describing methods for positive patient identification, patient preparation, specimen collection and container labeling, specimen preservation, conditions for transport and storage before testing are made available to the client. Laboratory Provide a list of acceptable patient identifiers to the clients; communicate the importance of the requirement and follow up with clients when inadequately labeled specimens are received. Communication and follow-up may be through written memoranda, phone calls, client visits or other means [sic] Provide instructions to the client to ensure all information contained on specimen label (s) agree with accompanying requisition that is ready for transport ... Provide immediate feedback to the client if there are issues recognized with positive patient identity at the time of collection ... Step Slide Labeling & Distribution Action Handle one slide and one requisition /worksheet at a time. The permanent slide label must be legible and indelible .. [sic] Handwritten and/or paper labels are not recommended for slide labeling. Use pre-printed or etched bar-coded slides. Histopathology Personnel: Handle one slide and one requisition/worksheet at a time. Match the slide/s to the paperwork and confirm positive ID and place it in the designated tray. Inform group lead/ supervisor of any Patient ID, other errors within a case or between cases; resolve and confirm proper ID by referring to gross description and or requisition." 2. Review of patient slides revealed: 3 slides were handwritten with the following: Slide 1: patient last name and first initial; date of birth 11/6/60; date of collection 6/10/21 Slide 2: patient last name and first initial; date of birth 11/6/60; date of collection 6/10/21 Slide 3: patient last name and first initial; date of birth 11/6/60; date of collection 6/10/21 10 barcoded H&E (hematoxylin and eosin) slides with the following information: Slide 1: Accession number NT21-10380-VV; A2; date of collection: 06/10/2021 Slide 2: Accession number NT21-10380-VV; A2; date of collection: 06/10/2021 Slide 3: Accession number NT21-10380-VV; A3; date of collection: 06/10/2021 Slide 4: Accession number NT21-10380-VV; A3; date of collection: 06/10/2021 Slide 5: Accession number NT21-10380-VV; A4; date of collection: 06/10/2021 Slide 6: Accession number NT21-10380-VV; A5; date of collection: 06/10/2021 Slide 7: Accession number NT21-10380-VV; A5; date of collection: 06/10/2021 Slide 8: Accession number NT21-10380-VV; FSA1; date of collection: 06/10/2021 Slide 9: Accession number NT21-10380-VV; FSA1; date of collection: 06/10/2021 Slide 10: Accession number NT21-10380-VV; A4; date of collection: 06/10/2021 3. Review of the Frozen Section Log revealed the following: The log had one column for collection date and another for "Full Patient Name/DOB Two Patient Identifiers" The collection date was "6/10/2021". The patient's first and last name was listed and a date of birth of "11/6/60". 4. Review of the patient's requisition listed the patient's date of birth as "11/06/1960". 5. Review of the patient's final report revealed a date of birth of "10/06/1960". The date of birth on the final report did NOT match the date of birth on the patient handwritten slides, frozen section log nor the patient requisition. The laboratory did not ensure positive identification and integrity of patient NT21-10380-VV from time of collection and receipt of the specimen through completion of testing and reporting of results. 6. During an interview on 04/11/2022 at 10:20 am, the Quality Assurance Coordinator confirmed the above findings.