| **Statement of Deficiencies** | **(X1) Provider/Supplier/CLIA Identification Number** | **(X3) Date Survey Completed** |
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| | 45D2148077 | 07/13/2026 |
| **Name of Provider or Supplier** | **Street Address, City, State** | |
| Pdp Of Texas Pllc | 7445 Las Colinas Blvd, Irving, 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 |
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| **D0000** | An onsite recertification survey was conducted on 07/13/2026. The laboratory was found to be in compliance with CLIA regulations 42 CFR Part 493. Standard level deficiencies were cited. |
| **D5209** | PERSONNEL COMPETENCY ASSESSMENT POLICIES<br>CFR(s): 493.1235<br><br>As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of laboratory procedures, Centers for Medicare & Medicaid Services (CMS) 209 form, personnel records, and confirmed in interview, the laboratory failed to establish written procedures to ensure competency assessment for two of two testing personnel (TP-1, TP-2) who performed dermatopathology slide interpretations. Findings included: 1. Review of the laboratory's written procedures did not include a procedure for competency assessments for individuals designated as testing personnel, as required. Testing personnel performed dermatopathology slide interpretations. 2. Review of the CMS 209 form identified two testing personnel, TP-1 and TP-2, who performed dermatopathology slide interpretations. 3. During an interview in the break room on 10/22/2025 at 12:02 PM, the laboratory representative confirmed written procedures did not include performing and documenting competency assessments for testing personnel who performed dermatopathology slide interpretations. |
| **D5217** | EVALUATION OF PROFICIENCY TESTING PERFORMANCE<br>CFR(s): 493.1236(c)(1)<br><br>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. |

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| | This STANDARD is not met as evidenced by:<br>Based on review of laboratory policies, laboratory twice annual accuracy records, and confirmed by staff interview, the laboratory failed to verify the accuracy of non-regulated dermatopathology slide interpretations at least twice annually for one of two testing events in 2025. Findings included: 1. Review of the laboratory's "Quality Assurance Program" policy stated: "Quality Assurance Indicators ... - Comparison of Test Results: Twice annually, slides from randomly chosen Mohs and in-house biopsy specimens will be sent to a dermatopathologist for evaluation of slide adequacy and second opinion of results from the Mohs surgery procedure. A request will be made for consulting slides to be returned to [XX], M.D., and accompanying reports will be filed in the Mohs laboratory as part of the quality assurance record." 2. Review of the laboratory's twice annual accuracy records for 2025 revealed only one event was performed in 2025. On 07/13/2026 at 10:34 AM in the break room, the laboratory was asked to provide documentation of a second event in 2025, and none was provided. The laboratory failed to have documentation of performing semi-annual accuracy assessments for dermatopathology slide interpretations in 2025. 3. During an interview in the break room on 07/13/2026 at 10:34 AM, the laboratory representative after a review of records confirmed, the laboratory failed to verify the accuracy of non-regulated dermatopathology slide interpretations at least twice annually for one of two testing events in 2025. |
| **D5805** | TEST REPORT<br>CFR(s): 493.1291(c)<br><br>(c) The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of the laboratory policies, Mohs maps, and confirmed in interview, the laboratory failed to include the key on the Mohs map for the symbols indicating the marking dyes on the sections used on 14 of 14 Mohs maps randomly reviewed in 2025 and 2026. Findings included: 1. Review of the laboratory's policy titled "Policy for Frozen Sections" stated: "Procedure ... 3. The tissue is then dissected and inked accordingly, symbols for ink colors are drawn in the tissue map. It is the policy of this laboratory to use five ink colors: red, yellow, black, and green. They are represented as follow on the Mohs map: [XXXX] - red [XXX] - yellow [XXX] - black ---- - green 2. Random review of 14 patient Mohs maps from April 2025, May 2025 and July 2026 showed symbols for the marking dyes used on the map, but there was no key to show what colors the symbols were, as listed by date of service and patient accession number: Date of service: 04/09/2025 Patient accession #: LW25-0474, LW25-0475, LW25-0476, LW25-0477 Date of service: 05/22/2025 Patient accession #: PK25-0085, PK25-0086, PK25-0087, PK25-0088 Date of service: 07/06/2026 Patient accession #: LW26-0922, LW26-0923, LW26-0924 Date of service: 07/07/2026 Patient accession #: LW26-0925, LW26-0926, LW26-00927 3. During an interview in |

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| | the break room on 07/13/2026 at 11:30 AM, the laboratory representative after a review of records confirmed, the laboratory failed to include the key on the Mohs map for the symbols indicating the marking dyes on the sections used on 14 of 14 Mohs maps randomly reviewed in 2025 and 2026. |
| **D6127** | TECHNICAL SUPERVISOR RESPONSIBILITIES<br>CFR(s): 493.1451(b)(9)<br><br>(b)(9) Evaluating and documenting the performance of individuals responsible for high complexity testing at least semiannually during the first year the individual tests patient specimens.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of laboratory policy manual, Center for Medicare & Medicaid Services (CMS) form 209, personnel records, and interview with staff, the technical supervisor failed to evaluate competency of one of two testing persons (TP-2) responsible for high complexity testing, at least semiannually during the first year of testing. Findings included: 1. Review of the laboratory's policy manual revealed the laboratory did not have a written policy for performing competency assessments for testing personnel who performed high complexity dermatopathology slide interpretations. Refer to D5209. 2. Review of the CMS 209 form revealed TP-2 performed dermatopathology slide interpretations. 3. Review of personnel for TP-2 listed a hire date 09/09/2024. The records did not include documented semiannual competency assessments for TP-2 during the first year of testing. 4. During an interview in the break room on 07/13/2026 at 9:54 AM, the laboratory representative, after a review of records, confirmed the technical supervisor failed to evaluate competency of one of two testing persons (TP-2) responsible for high complexity testing, at least semiannually during the first year of testing. |
| **D6128** | TECHNICAL SUPERVISOR RESPONSIBILITIES<br>CFR(s): 493.1451(b)(9)<br><br>(b)(9) Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individuals performance must be reevaluated to include the use of the new test methodology or instrumentation.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of laboratory policy manual, Center for Medicare & Medicaid Services (CMS) form 209, personnel records, and interview with staff, the technical supervisor failed to evaluate annual competency of one of two testing persons (TP-1) responsible for high complexity testing in 2025. Findings included: 1. Review of the laboratory's policy manual revealed the laboratory did not have a written policy for performing competency assessments for testing personnel who performed high complexity dermatopathology slide interpretations. Refer to D5209. 2. Review of the CMS 209 form revealed TP-1 performed dermatopathology slide interpretations. 3. Review of personnel records did not include documented annual competency assessments for TP-1 in 2025. 4. During an interview in the break room on 07/13 /2026 at 9:54 AM, the laboratory representative, after a review of records, confirmed the technical supervisor failed to evaluate annual competency of one of two testing persons (TP-1) responsible for high complexity testing in 2025. Note: During 2024 |

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| | and 2025 TP-1 was NOT the laboratory director or technical supervisor and did not fulfil the duties and responsibilities as delegated on the CMS 209 form collected on the date of the survey. |