Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 45D2163132	(X3) Date Survey Completed 05/10/2022
Name of Provider or Supplier South Tx Skin Cancer Center - Ah	**Street Address, City, State** 2632 Broadway, Ste 300, San Antonio, 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	Noted deficiencies and plans of correction were discussed with the laboratory representatives at the entrance and exit conferences. The facility representatives were given an opportunity to provide evidence of compliance with the noted deficiency, and no such evidence was provided prior to survey exit. The facility was found to be in compliance with applicable Conditions of Participation in the CLIA program, and certification is recommended. 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 Dallas Regional Office (RO) 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.
D5601	HISTOPATHOLOGY CFR(s): 493.1273(a)(f) (a) As specified in 493.1256(e)(3), fluorescent and immunohistochemical stains must be checked for positive and negative reactivity each time of use. For all other differential or special stains, a control slide of known reactivity must be stained with each patient slide or group of patient slides. Reactions of the control slide with each special stain must be documented. (f) The laboratory must document all control procedures performed, as specified in this section. This STANDARD is not met as evidenced by: Based on review of the laboratory's procedures, review of the laboratory's slide quality control records from October 2021 to December 2021, review of patient test records and staff interview, it was revealed the laboratory failed to have documentation of evaluating stain quality for 7 of 31 (23%) days of testing. The findings were: 1. Review of the laboratory's quality assurance procedure under the section titled "8.0 Quality Control" revealed: "A quality control slide will be the first slide of the day

	produced. The quality control slide will be reviewed by the Mohs surgeon and the Quality Control Slide Log will be annotated." 2. A review of the laboratory's Quality Control Slide Log from October 2020 revealed the laboratory failed to have documentation of the acceptability of stain quality for 7 of 31 test days. The days without the required documentation were: October 6, 2021 October 18, 2021 October 19, 2021 October 27, 2021 October 29, 2021 November 5, 2021 December 15, 2021 3. A review of patient test records revealed the following number patients tested on the identified days: a) October 6, 2021 13 patients Accession numbers 697 - 710 b) October 18, 2021 16 patients Accession numbers 743 - 758 c) October 19, 2021 13 patients Accession numbers 759 - 771 d) October 27, 2021 14 patients Accession numbers 779 - 793 e) October 29, 2021 7 patients Accession numbers 793 - 799 f) November 5, 2021 8 patients Accession numbers 882 - 829 g) December 15, 2021 13 patients Accession numbers 984 - 996 4. An interview with Facility Manager on May 10, 2022 at 1119 hours in the conference area - after his review of the records- confirmed the findings. NOTE: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED 12/09/2020