Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	53D0519668	04/29/2025
Name of Provider or Supplier	**Street Address, City, State**	
Cheyenne Skin Clinic	123 Western Hills Blvd, Cheyenne, WY	

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
D2003	ENROLLMENT CFR(s): 493.801(a)(2)(ii) (2)(ii) For those tests performed by the laboratory that are not included in subpart I of this part, a laboratory must establish and maintain the accuracy of its testing procedures, in accordance with 493.1236(c)(1). This STANDARD is not met as evidenced by: Based on review of proficiency testing records, staff interview, and policy and procedure review, the laboratory failed to ensure the microscopic evaluation of dermatological histopathology slides was performed twice annually for 1 of 2 Mohs surgeons (MD #1) and 1 of 2 dermatologists (MD #2) for 2 of 2 years (2023, 2024) reviewed: The findings were: 1. Review of the proficiency testing records showed the following concerns: a. The laboratory's records for MD #1 showed a peer review of a Mohs case was performed on 3/10/23; however, there was no evidence a second case had been assessed for accuracy. b. The laboratory's records for MD #2 showed an independent offsite evaluation was completed on 10/17/23; however; there was no evidence a second case had been assessed for accuracy. The laboratory was unable to locate any documentation for 2024. 2. Interview with MD #3 on 4/29/25 at 12:29 PM confirmed there was no documentation of a second accuracy assessment in 2023 for MD #1. 3. Interview with MD #2 on 4/29/25 at 12:35 PM confirmed an independent offsite evaluation had not been completed. 4. Review of the "MOHS Surgery and Proficiency Testing" policy, effective 10/7/21, showed "...2. Proficiency testing will be assessed at least semiannually. 3...Semiannually MOHS surgeons shall randomly select a minimum of 1 cases (sic) 2 times per year per MOHS surgeon..." 5. Review of the "PROFICIENCY TESTING" policy, revised on 10/26/21" showed "1. Slides shall be sent to another laboratory for evaluation and interpretation. At least twice per year reports shall be reviewed and evaluated for proficiency."
D5209	PERSONNEL COMPETENCY ASSESSMENT POLICIES

CFR(s): 493.1235

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.

This STANDARD is not met as evidenced by:
Based on review of the CMS (Centers for Medicare and Medicaid Services) 209 Laboratory Personnel Report, review of personnel and laboratory records, policy and procedure review, and staff interview, the laboratory failed to ensure initial, 6-month, and annual competency assessments were completed for 9 of 9 testing personnel (MD #1, MD #2, MD #3, MD #4, NP #1, NP #2, PA #1, PA #2, PA #3) as required for 2 of 2 years reviewed (2023, 2024). In addition, the laboratory failed to develop a procedure for assessing the competency of the clinical consultant, technical consultant, and general supervisor. The findings were: 1. Review of the CMS 209 Laboratory Personnel Report showed MD #1, MD #2, MD #3, MD #4, NP #1, NP #2, PA #1, PA #2, and PA #3 were listed as testing personnel. Review of the laboratory's records showed fungal testing was performed using KOH (potassium hydroxide) and DTM (dermatophyte test media) by each of the testing personnel listed. The following concerns were identified: a. Review of the personnel file for MD #1 showed a proficiency testing event had been completed on 3/14/23 and 12/9/24. There was no evidence a competency assessment had been conducted which included the direct observation of routine test performance, problem solving, and quality control. b. Review of the personnel file for MD #2 showed a proficiency testing event had been completed on 3/14/23 and 10/29/24. There was no evidence a competency assessment had been conducted which included the direct observation of routine test performance, problem solving, and quality control. c. Review of the personnel file for MD #3 and MD #4 showed a proficiency testing event had been completed on 3/13/23 and 10/28 /24. There was no evidence a competency assessment had been conducted which included the direct observation of routine test performance, problem solving, and quality control. d. Review of the personnel file for NP #1 showed a proficiency testing event had been completed on 3/13/23 and 10/30/24. There was no evidence a competency assessment had been conducted which included the direct observation of routine test performance, problem solving, and quality control. e. Review of the personnel file for NP #2 showed no evidence competency assessments had been conducted which included the direct observation of routine test performance, problem solving, quality control, and proficiency testing (or other blind specimens) in 2023 or 2024. f. Review of the personnel file for PA #1 showed a proficiency testing event had been completed on 3/14/23 and 10/25/24. There was no evidence a competency assessment had been conducted which included the direct observation of routine test performance, problem solving, and quality control. g. Review of the personnel file for PA #2 showed she was hired on 1/1/24. There was no evidence an initial, 6-month, or annual competency assessment had been completed. Review of the patient testing logbook showed PA #2 performed approximately 38 fungal tests in 2024. h. Review of the personnel file for PA #3 showed she was hired on 3/1/24 and a proficiency testing event had been completed on 10/24/24. There was no evidence an initial, 6-month, or annual competency assessment had been completed. Review of the patient testing logbook showed PA #3 performed approximately 86 fungal tests in 2024. 2. There was no evidence a procedure and been developed to assess the duties of the clinical consultant, technical supervisor, and general supervisor. 3. Interview with the practice administrator on 4/29/25 at 10:44 AM confirmed no further documentation was available. 4. Review of the "DTM/Dermatophyte Test Medium Fungal Cultures"

	and "KOH" policies, effective 10/7/21, showed "...Physicians and mid-level providers will be trained on preparation and reading of [DTMs and KOHs] and follow the Laboratory's established policy for the evaluation of testing personnel for moderate complexity testing. Upon hire, testing shall be conducted at least semi-annually for the first year and annually following the first year of employment. 5. Review of the "NON-WAIVED TEST COMPETENCY" policy showed "1. During the first year of an individual's duties, or a new method/test, competency will be assessed at least semi-annually. 2. Annual Competency Assessment shall include six elements for each lab employee, on each test system, unless an element is not applicable to the test system. 3. The Lab Director shall review Laboratory Personnel Competency Assessments for efficiency. 4. Technical consultant shall evaluate and document of the performance of individuals responsible for moderate complexity testing annually after the first year. 5. Mid-level practitioner performing mycology testing shall be reviewed annually for their competency to read, report and troubleshoot KOH skin scraping preparations and DTM cultures."