Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	05D2115868	02/05/2026
Name of Provider or Supplier	**Street Address, City, State**	
San Diego Family Dermatology	655 Euclid Ave, Ste 304, National City, CA	

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
D5217	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1) 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. This STANDARD is not met as evidenced by: Based on review of 2025 laboratory records for Mohs procedures and the laboratory written policy titled, "Verification of Test Accuracy/ Mohs Peer Review Policy", the lack of laboratory records, and interview with laboratory personnel, it was determined the laboratory failed to at least twice annually verify the accuracy of Mohs procedures performed in 2025. Findings included: a. Laboratory records documented hundreds of Mohs procedures performed in 2025, including four selected for this Survey, as follows: Date Mohs Case # ---------- 1/29/25 NC25 - 30 5/20/25 NC25 - 124 9/09/25 NC25 - 202 12/02/25 NC25 - 302 b. The laboratory policy for verifying the accuracy of Mohs procedures stated to "send a minimum of one Mohs case, two times per calendar year, for review/blind testing...". c. Laboratory records documented peer review on 4/09/25. The laboratory was unable to provide for this Survey: records documenting peer review a second time in 2025. d. Laboratory personnel affirmed (2/05/26 at 12:30 PM) the aforementioned findings. e. And thus, the laboratory failed to comply with the laboratory policy and this regulation. The accuracy, reliability, and quality of Mohs procedures performed in 2025 could not be assured during this Survey. The laboratory performed 400 Mohs procedures annually (CMS116 CLIA Application, 2/03/26). .
D5787	TEST RECORDS CFR(s): 493.1283(a) (a) The laboratory must maintain an information or record system that includes the following: (a)(1) The positive identification of the specimen. (a)(2) The date and time

	of specimen receipt into the laboratory. (a)(3) The condition and disposition of specimens that do not meet the laboratory's criteria for specimen acceptability. (a)(4) The records and dates of all specimen testing, including the identity of the personnel who performed the test(s). This STANDARD is not met as evidenced by: Based on review of laboratory records including patients chart notes and Mohs slides, and interview with laboratory personnel, it was determined the laboratory failed to maintain accurate test records. Findings included: a. Mohs case # NC23-259 1. The Mohs map and slides documented the procedure required I stage, but the chart operative notes stated II stages. b. Mohs case # NC24 -95 1. The chart notes and Mohs map documented the procedure was performed on 4/24/24, but slides were dated 4/23 /24. c. Mohs case # NC25 - 30 1. The chart notes and Mohs map documented the procedure was performed on 1/29/25, but slides were dated 1/28/25. d. Mohs case # NC25 - 302 1. The Mohs map and slides documented the procedure was performed on the Nasal Tip, but the chart stated Nasal Bridge. e. KOH on 9/11/25 for GA541510 1. The KOH log book recorded the KOH result as Negative, but there was no documentation in the patient's chart for requesting the KOH test or the test result. f. Laboratory personnel affirmed (2/05/26 at 12:30 PM) the aforementioned findings of discrepancies. g. The reliability and quality of the test records could not be assured during this Survey. .
D5791	ANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1289(a)(c) (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 analytic systems specified in 493.1251 through 493.1283. This STANDARD is not met as evidenced by: Based on the findings and deficiencies cited, it was determined the laboratory failed to establish procedures for ongoing review processes to monitor the test records, assess for accuracy, identify errors, and make timely corrections. Findings included: a. See D5217. The laboratory failed to comply with laboratory policy requiring peer review two times within the calendar year. b. See D5787. Test records from 2023 - 2025 had errors that weren't identified prior to this Survey on 2/05/26. .
D6079	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(a)(b) The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations. (a) The laboratory director, if qualified, may perform the duties of the technical supervisor, clinical consultant, general supervisor, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications under 493.1447, 493.1453, 493.1459, and 493.1487 respectively. (b) If the laboratory director reapportions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed.

	This STANDARD is not met as evidenced by: Based on the findings and deficiencies cited during this Survey, the Laboratory Director is herein cited for deficient practice in monitoring activities to ensure compliance. Findings included: a. The Laboratory Director was deficient in the practice of monitoring annual peer reviews to ensure compliance. See D5217. b. The Laboratory Director was deficient in the practice of monitoring test records for accuracy and reliability. See D5787. c. The Laboratory Director was deficient in the practice of establishing and monitoring effective quality assurance processes for reviewing test records and correcting errors. See D5791. .