Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	07D1105416	07/07/2026
Name of Provider or Supplier	**Street Address, City, State**	
Long Ridge Dermatology	1051 Long Ridge Rd, Stamford, CT	

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 record review and staff interview, the laboratory failed to follow their established 'Proficiency Testing' (PT) policies and procedures by not submitting two micrographic surgery (MOHS) cases semiannually for PT without including any differential diagnosis in the subspecialty of histopathology. Findings include: 1. Record review on 07/07/2026 of the laboratory's 2025 'Semi Annually - Quality Assurance - Quality Control Proficiency Testing' forms revealed the following: a. One of one MOHS case was sent out for external consultation on 05/11/2025. i. Differential diagnosis included: 'Squamous Cell Carcinoma'. b. One of one MOHS case was sent out for external consultation on 11/06/2025. i. Differential diagnosis included: 'Basal Cell Carcinoma'. c. Lack of documentation of two MOHS cases sent out for external consultation semiannually as indicated in the laboratory's policies and procedures 2. Record review on 07/07/2026 of the laboratory's 'Proficiency Testing' policies and procedures revealed the following: a. 'Semi-annually, the tech or Risk Manager will send two cases containing the original slides, label it with only the surgical case number, and send it out for microscopic examination by a board-certified Dermatopathologist'. b. 'No differential diagnosis will be offered with the specimen'. 3. Staff interview on 07/07/2026 at 11:45 AM with the laboratory histotechnician confirmed the above findings. 4. The laboratory performs 150 MOHS cases annually in the subspecialty of histopathology.
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 record review and staff interview, the laboratory failed to establish competency assessment policies and procedures to assess competency for the regulatory responsibilities of the clinical consultant (CC). Findings include: 1. Record review on 07/07/2026 of the laboratory's 'Centers for Medicare & Medicaid Services (CMS) 209 form - Laboratory Personnel Report' revealed one of one CC is listed. 2. Record review on 07/07/2026 of the staff training and competency files for 2024 and 2025 revealed lack of competency assessment policies and documented competency assessment records for the regulatory position of CC. 3. Staff interview on 07/07/2026 at 09:40 AM with the laboratory histotechnician confirmed the above findings. 4. The laboratory performs 150 micrographic surgery cases annually in the subspecialty of histopathology.
D5413	TEST SYSTEMS, EQUIPMENT, INSTRUMENTS, REAGENT CFR(s): 493.1252(b) (b) The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (b)(1) Water quality. (b)(2) Temperature. (b)(3) Humidity. (b)(4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory failed to ensure that the acceptable humidity ranges listed on the laboratory's humidity log are consistent with manufacturer's instructions in the subspecialty of histopathology. Findings include: 1. Record review on 07/07/2026 of 'The Avantik QS12 and QS12UV Cryostat' manufacturer's manual revealed an acceptable relative humidity of 'Max. 60% Relative Humidity'. 2. Record review on 07/07/2026 of the laboratory's 'Room Temp /Humidity' log revealed the following: a. Laboratory's acceptable humidity range: 60% to 75%. b. 40 of the 40 working days in 2025 and 21 of 21 working days in 2026, recorded humidity was within the laboratory's acceptable operating range (60%-75%), but outside the humidity range specified by the manufacturer listed in line item 1 above. 3. Staff interview on 07/07/2026 at 11:15 AM with the laboratory histotechnician (HT) confirmed the above findings. The HT further commented that he /she was unaware of the manufacturer requirement of 'Max. 60% Relative Humidity'. 4. The laboratory performs 150 micrographic surgery cases annually in the subspecialty of histopathology.
D5779	CORRECTIVE ACTIONS CFR(s): 493.1282(a) (a) Corrective action policies and procedures must be available and followed as

	necessary to maintain the laboratory's operation for testing patient specimens in a manner that ensures accurate and reliable patient test results and reports. This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory failed to follow their established proficiency testing (PT) policies and procedures and to document a corrective action when a discrepancy occurred for the same test performed on the same sample at multiple testing sites in the subspecialty of histopathology. Findings Include: 1. Record review on 07/07/2026 of the first 2025 'Semi Annually - Quality Assurance - Quality Control Proficiency Testing' form for peer review cases revealed the following: a. Differential diagnosis provided to the consulting dermatopathologist as: squamous cell carcinoma. b. Consulting Dermatopathologist Diagnosis: 'Tumor Present: No'. c. Lack of documentation of a correction action for the resolution of the above disagreement in the final diagnosis. 2. Record review on 07/07/2026 of the laboratory's PT standard operating procedure revealed the following: a. 'In the event the pathology report from the dermatopathologist does NOT match the in house diagnosis by the physician, an identical slide will be sent, by the tech or risk manager to another outside laboratory chosen from the list below, for microscopic examination'. b. Lack of documentation of a correction action for the resolution of the disagreement in the final diagnosis listed in 1(b) above. 3. Staff interview on 07/07 /2026 at 12:00 PM with the laboratory histotechnician confirmed the above findings. 4. The laboratory performs 150 micrographic surgery cases annually in the subspecialty of histopathology.
D6093	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) (e)(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur; This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory director (LD) failed to review and sign off on the 'Quarterly Patient Quality Assurance Checklist' (QPQAC) and ensure the laboratory personnel are following their established quality assurance policies and procedures to document quarterly quality assessments in the subspecialty of histopathology. Findings include: 1. Record review on 07/07/2026 of the laboratory's QPQAC's revealed the following: a. In 2024, the QPQAC was completed on 01/07/2024, 05/05/2024 and 09/02/2024. b. In 2025, the QPQAC was completed on 01/06/2025, 05/10/2025 and 09/25/2025. c. Lack of documentation of all four quarterly QPQAC's were performed. d. Lack of documentation of LD review and sign off on the above quality assessments listed in 1(a) through (b). 2. Record review on 07 /07/2026 of the laboratory's 'Quality Assurance' policies and procedures revealed the following: a. 'Quarterly the nurse or tech will check off the quarterly quality assurance checklist'. b. 'The lab director will also review and sign off the checklist quarterly'. c. Lack of documentation of quarterly QPQAC performance and LD review and sign off for the items listed in 1(a) through (b) above. 3. Staff interview on 07/07/2026 at 11: 30 AM with the laboratory histotechnician confirmed the above findings. 4. The laboratory performs 150 micrographic surgical cases annually in the subspecialty of histopathology.

D6120	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(7)(8) (b)(7) Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed; (b)(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. This STANDARD is not met as evidenced by: Based on record review and staff interview, the technical supervisor failed to evaluate and maintain the competency assessment of high complexity testing personnel (TP) in the subspecialty of histopathology. Findings include: 1. Record review on 07/07/2026 of the laboratory 'Centers for Medicare & Medicaid Services (CMS) 209 form - Laboratory Personnel Report' revealed one of one TP is listed. 2. Record review on 07 /07/2026 of the staff training and competency files for 2024 and 2025 revealed lack of competency assessment policies and documented competency assessment using the six competency assessment procedures for the TP listed in line item 1 above. 3. Staff interview on 07/07/2026 at 09:45 AM with the laboratory histotechnician confirmed the above findings. 4. The laboratory performs 150 micrographic surgery cases annually in the subspecialty of histopathology.