Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	07D2071728	05/13/2026
Name of Provider or Supplier	**Street Address, City, State**	
Connecticut Dermatology Group, Pc	233 Broad Street, Suite 1, Milford, 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
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 for the clinical consultant (CC). Findings include: 1. Record review on 05/13/2026 of the staff training and competency files revealed lack of competency assessment policies and documented competency assessment records for the regulatory position of CC. 2. Staff interview on 05/13/2026 at 09:30 AM with the laboratory general manager confirmed the above finding.
D5891	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(a) (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 postanalytic systems specified in 493.1291. This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory failed to revise its policies and procedures and to implement appropriate corrective actions when errors were identified in the postanalytical system within the subspecialty of histopathology. Findings include: 1. Record review on 05/13/2026 of the laboratory's 'Corrective Action Log' revealed the following documented incidents: a. 'Date: 10/20/25': i.

	'Incident: diagnosis was listed as SCC instead of BCC in op note'. ii. 'Was Testing Compromised? No'. iii. 'Corrective Action: MOHS op note was amended'. b. 'Date: 3 /16/26': i. 'Incident: Dx in MOHS note was listed as SCC. Correct Dx is BCC'. ii. 'Was Testing Compromised? No'. iii. 'Corrective Action: MOHS op note was amended'. c. Lack of documentation demonstrating that effective corrective actions were implemented, including evidence of staff retraining and revisions to policies and procedures designed to prevent recurrence. 2. Record review on 05/13/2026 of the patient #1 final test report for the dated incident on '10/20/25' revealed the following: a. 'Pathology Report': i. 'Diagnosis: Basal Cell Carcinoma, Nodular, Transected'. ii.'Date Reported: 08/15/2025 11:00'. b. 'Visit Note - October 20, 2025': i. 'Preop Diagnosis: Squamous Cell Carcinoma'. ii. 'Postop Diagnosis: Squamous Cell Carcinoma'. iii. 'Electronically Signed By: TP#1, 10/20/2025 at 03:20 PM EDT'. iv. 'Correction: Diagnosis is Basal Cell Carcinoma'. v. 'Electronically Signed By: TP#1, 11/12/2025 at 09:52 AM EST'. 3. Record review on 05/13/2026 of the patient #2 final test report for the dated incident on '3/16/26' revealed the following: a. 'Pathology Report': i. 'Diagnosis: Basal Cell Carcinoma, Nodular Type'. ii. 'Date Reported: 02/10 /2026 12:45'. b. 'Visit Note - March 16, 2026': i. 'Preop Diagnosis: Squamous Cell Carcinoma'. ii. 'Postop Diagnosis: Squamous Cell Carcinoma'. iii. 'Electronically Signed By: TP#1, 03/16/2026 at 04:21 PM EDT'. iv. 'Correction: Diagnosis is Basal Cell Carcinoma'. v. 'Electronically Signed By: TP#1, 04/08/2026 at 08:51 AM EDT. 4. Record review on 05/13/2026 of the laboratory's 'Quality Management Program' policies and procedures revealed the following: a. 'Quality issues will be documented, and corrective action plan will be created and implemented. The effectiveness of the corrective action will be assessed'. b. 'Retraining (with documentation) will occur as needed'. c. 'Policies and procedures will be revised as needed by the SDG CLIA team in collaboration with and approval from the lab director. All revisions will be reviewed with staff/staff will be trained on revisions'. d. 'In addition to this bi-annual assessment, laboratory quality may be assessed at any time. Findings, plans of correction, and assessment of POC effectiveness will be documented on the Corrective Action Log'. 5. Staff interview on 05/13/2026 at 11:15 AM with the laboratory general manager confirmed the above findings. 6. The laboratory performs 700 tests annually in the subspecialty of histopathology.