Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D0691628	04/08/2026
Name of Provider or Supplier	**Street Address, City, State**	
Advanced Dermatology & Cosmetic Surgery	202 Lake Miriam Dr S-1, Lakeland, FL	

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	An announced CLIA recertification survey was conducted at Advanced Dermatology & Cosmetic Surgery on 04/08/2026. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
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 record review and interview, the laboratory failed to verify the accuracy of Mycology testing, the identification of fungus, twice annually for two of two years reviewed (2024 and 2025) for one of one (A) testing personnel (TP). The lab performed 14 tests. Findings included: 1. The CMS-116 CLIA Application for Certification form, signed by the Laboratory Director 04/07/2026 was reviewed. The laboratory performed moderate complexity testing to identify fungus. 2. The CMS-209 Laboratory Personnel Report, signed by the Laboratory Director on 04/07/2026 was reviewed. The CMS-209, signed by the previous Laboratory Director on 04/16/24 was reviewed. TP A was listed on both forms reflecting they were performing moderate complexity testing for the last two years. 3. The laboratory policy and procedure manual, signed by the Laboratory Director 03/10/2025 and 07/11/2025 was reviewed. There was no policy regarding the verification of Mycology testing twice annually. 4. TP A's personnel records were reviewed. There was no evidence of twice annual verification of accuracy for Mycology. 5. An interview with the Senior Location Manager on 04/08/2026 at 1:00 p.m. confirmed the above. 6. The Laboratory Director was interviewed at 1:30 p.m. on 04/08/2026. They stated they were not aware of the failure to verify the accuracy twice annually for TP A for 2024 or 2025.
D6046	TECHNICAL CONSULTANT RESPONSIBILITIES

	CFR(s): 493.1413(b)(8) (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. The procedures for evaluation of the competency of the staff must include, but are not limited to-- This STANDARD is not met as evidenced by: Based on record review and interview, the Technical Consultant failed to perform a semiannual competency evaluation on one of one (B) testing personnel (TP) that required a semiannual evaluation in 2026 and failed to perform an annual competency evaluation on one of one (A) TP for 2024 and 2025. Findings included: 1. The CMS-116 CLIA Application for Certification form, signed by the Laboratory Director 04/07 /2026 was reviewed. The laboratory performed moderate complexity testing. 2. The CMS-209 Laboratory Personnel Report, signed by the Laboratory Director on 04/07 /2026 was reviewed. The CMS-209, signed by the previous Laboratory Director on 04 /16/24 was reviewed. TP A was listed on both forms. TP B was only listed on the 2026 form. 3. Interview with the Senior Location Manager at approximately 1:00 p.m. on 04/08/2026 revealed TP A had been with the laboratory greater than two years and TP B was hired in 09/2025. 4. The laboratory policy and procedure manual, signed by the Laboratory Director 01/20/2026, 03/10/2025 and 07/11/2025 was reviewed. New TP should have a competency evaluation semiannually. Established employees require an annual evaluation. 5. The personnel records for both TP A and B were reviewed. There was no 2024 or 2025 competency evaluation for TP A. There was no semiannual competency evaluation for TP B. 6. The Laboratory Director was interviewed on 04/08/2026 at 1:30 p.m. They were unaware of the above. 7. An unnamed form, signed by the Laboratory Director 01/20/2026 was reviewed. The form had the typed statement in all caps "As Lab Director of ADCS Laboratory, I have reviewed the competency assessments of all lab personnel".
D6080	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(c) (c) The laboratory director must: (c)(1) Be onsite at least once every 6 months, with at least 4 months between the minimum two on-site visits. Laboratory directors may elect to be on-site more frequently and must continue to be accessible to the laboratory to provide telephone or electronic consultation as needed; and (c)(2) Provide documentation of these visits, including evidence of performing activities that are part of the laboratory director responsibilities. This STANDARD is not met as evidenced by: Based on record review and interview the Laboratory Director failed visit the laboratory once every six months in 2025, missing 1 of 2 visits in 2025. Findings included: 1. The laboratory policy and procedure manual, signed by the Laboratory Director 03/10/2025 and 07/11/2025 was reviewed. The policy titled Medical Laboratory Director Qualifications and Responsibilities with an effective date of 04/21 /2025 was reviewed. The policy required a documented visit once every six months. 2. A Laboratory Director Laboratory Visit Form, signed by the Laboratory Director on 06 /12/2025, was reviewed. No other Visit Form could be located. 3. The Laboratory Director was interviewed on 04/08/2026 at 1:30 p.m. They were not aware they failed to perform the second six month visit.

D6102	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(12) (e)(12) Ensure that prior to testing patients specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results; This STANDARD is not met as evidenced by: Based on record review and interview, the Laboratory Director failed to ensure one of one (B) new testing personnel (TP) was evaluated and deemed competent prior to performing moderate complexity Mycology testing. Findings included: 1. The CMS-116 CLIA Application for Certification form, signed by the Laboratory Director 04/07 /2026 was reviewed. The laboratory performed moderate complexity testing to identify fungus. 2. The CMS-209 Laboratory Personnel Report, signed by the Laboratory Director on 04/07/2026 was reviewed. The CMS-209, signed by the previous Laboratory Director on 04/16/24 was reviewed. TP B was listed on the 2026 form as performing moderate complexity testing. They were not listed on the 2024 CMS-209 reflecting they were a new employee since the previous survey. 3. The laboratory policy and procedure manual, signed by the Laboratory Director 03/10 /2025 and 07/11/2025 was reviewed. The Laboratory Director is to "Ensure that, prior to testing patients' specimens, all personnel... receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results." 4. The Senior Location Manager was interviewed at approximately 1:00 p.m. on 04/08/2026. TP B's date of hire was 09/2025. 5. TP B's personnel records were reviewed. There was no evaluation of competency to report accurate Mycology test results. 6. The Laboratory Director was interviewed on 04/08/2026 at 1:30 p.m. They were unaware TP B did not have an initial evaluation prior to testing. 7. An unnamed form, signed by the Laboratory Director 01/20/2026 was reviewed. The form had the typed statement in all caps "As Lab Director of ADCS Laboratory, I have reviewed the competency assessments of all lab personnel".