Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D0978533	08/06/2026
Name of Provider or Supplier	**Street Address, City, State**	
Skin And Cancer Associates Llp	3275 N Sr 7, Margate, 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 SKIN AND CANCER ASSOCIATES LLP from August 04, 2026 to August 06, 2026. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
D5433	MAINTENANCE AND FUNCTION CHECKS CFR(s): 493.1254(b)(1) (b)(1)(i) Establish a maintenance protocol that ensures equipment, instrument, and test system performance that is necessary for accurate and reliable test results and test result reporting. (b)(1)(ii) Perform and document the maintenance activities specified in paragraph b(1)(i) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, the laboratory failed to document maintenance for the manual Hematoxylin & Eosin staining for one out of eight testing days during February 2026, and failed to document maintenance for the Leica DME microscope for five (December 2024, March 2025, August 2025, November 2025 and February 2026) out of six months reviewed (December 2024, March 2025, August 2025, November 2025 February 2026 and June 2026). Findings included: 1-Review of the daily "Quality Control Worksheet Modified Routine Hematoxylin & Eosin Individual Chemical Analysis Log" revealed that on 02/20 /2026 there was no recorded actions for alcohol and clearing reagents. 2- Review of the daily "MOHS ACCESSION LOG" listed accessions M26-135 to M26-143 (nine patients) on 02/20/2026 who had Mohs surgical procedure. 3-Review of the procedure for the "Quality Control Measures for the Individual Stain Chemicals in the Modified Routine Hematoxylin & Eosin (H&E) Stain Line" signed by the Laboratory Director on 06/08/2026 stated that "The chemicals used in the laboratory are analyzed and monitored every day that the stain line is placed into use" ..." Only those chemicals that are in need of adjustment will be modified. The following codes will used to

	indicate what measures have been taken to ensure high standard results:" 4- Review of the laboratory maintenance records for random months December 2024, March 2025, August 2025, November 2025, revealed that the laboratory did not document maintenance for the microscope after used by the Mohs surgeon. 5- Review of the Microscope Preventive Maintenance procedure signed by the Laboratory Director on 06/08/2026 stated "Proper care and preventive maintenance should be performed and documented daily or after use in order to ensure proper performance." 6- Review of the daily "MOHS ACCESSION LOG" listed accessions numbers for patients tested as followed: M24-519 to M24-566: 47 patients tested during December 2024 M25-125 to M25-186: 61 patients tested during March 2025 M25-417 to M25-496: 79 patients tested during August 2025 M25-614 to M25-677: 63 patients tested during November 2025 M26-086 to M26-164: 78 patients tested during February 2026 7-Interview on 08 /06/2024 at 2:15 PM the Quality Assurance Consultant confirmed that the daily H&E stain log was not completed for 02/20/2026 and that there was no record of daily microscope maintenance on days of testing from five months reviewed.
D5609	HISTOPATHOLOGY CFR(s): 493.1273(e)(f) (e) The laboratory must use acceptable terminology of a recognized system of disease nomenclature in reporting results. (f) The laboratory must document all control procedures performed, as specified in this section. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the laboratory failed to document quality control records of the chemicals used in the Histology laboratory including lot numbers, received dates, open dates, expiration dates for all the reagents used for the Hematoxylin & Eosin (H&E) Stain from 07/16/2024 to 01/21/2026. Findings included: 1. During a tour of the laboratory on 08/04/2026 at approximately 10:56 AM observed that the laboratory had in use the following reagents: a. EOSIN MERCEDES SCIENTIFIC (MER) MA 1015 lot #237898 opened 07/02/2026 (expiration date 03/31/2027), b. Hematoxylin Stain Gill III (MER) lot 2522345 opened 03/13/2026 (expiration date 08/21/2027), c. XS-3 Xylene Substitute (Stat Lab) lot 248068 opened 07/09/2026 (expiration date 01/31/2028), and d. 100% Reagent Alcohol (MER) lot 2615202 opened 07/16/2026 (expiration date 12/03/2028) 2. Review of the Laboratory Reagent Log revealed that laboratory did not have record for reagent tracking from 07/16/2024 to 01/21/2026. 3. On 08/04/2026 at 11:15 AM the Quality Assurance Consultant confirmed that there was no documentation for reagents in histology laboratory prior to 01/22/2026.
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 laboratory failed to have the Technical

	Supervisor (TS) or a designee, evaluate the competency of Testing Personnel for testing in the Histology laboratory for three Testing Personnel (TP-B since 07/16 /2024, TP-A and TP-B since they started 06/06/2026) of three TP (TP-A, TP-B, TP-C) through August 4, 2026. Findings included: 1-Review of FORM CMS 209 signed by the Laboratory Director on 08/03/2026, revealed the following: Laboratory Director (LD) was also Clinical Consultant (CC). The laboratory had a Technical Supervisor (TS) and General Supervisor (GS), who was also TP-B. The laboratory also had TP-A and TP-C who started June 06, 2026. 2- Review of the personnel competency records revealed the following: a. TP-B had delegation signed by the LD on 10/18/2018 to perform competency assessments b. Review of personnel record's annual competency revealed no annual competency evaluations from 07/16/2024 to August 04, 2026, for TP-B. The LD signed a competency evaluations record for TP-B on 01/2021. 3- Review of the Monthly QUALITY ASSURANCE CHECKLIST signed by the LD 7/24/2026 was marked Yes (Y) under Personnel Policies for "Y All Personnel who perform tests have documented training". Based on lack of records for competency evaluations TP-A and TP-C there were no competency assessments performed in 2026 for new personnel. 4-Review of the MOHS QUALITY ASSURANCE MANUAL signed by the LD on 06/08/2026 stated in section "IX. PERSONNEL ASSESSMENT: The Laboratory Director will use personal observation to perform an ongoing evaluation of all employees of the laboratory to ensure competence in the lab performance." The laboratory did not have a documented form to assess personnel performance. 5- On 08/04/2026 at 11:15 AM the Quality Assurance Consultant confirmed that the initial assessments for TP-A and TP-C were not done, and that the laboratory did not have annual competency evaluations for TP-B since July 2024 to August 2026.