Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D1023477	10/23/2025
Name of Provider or Supplier	**Street Address, City, State**	
Surgical Pathology Laboratories Pa-Mlu #10	8455 66th St N, Pinellas Park, 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 Surgical Pathology Laboratories PA-MLU #10 on 10/23/2025. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
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 to develop a policy or provide evidence of the required onsite visits from 12/2024 to 10/2025. Findings Included: 1. Review of records revealed no policy regarding the Laboratory Director being onsite every 6 months and no evidence of visits from 12/2024 to 10 /2025. 2. During an interview on 10/23/2025 at 11:56 p.m., the Lab Director confirmed that the lab did not have a policy regarding the mandatory visits or documentation of the visits
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 that prior to testing patients' specimens, one Testing Personnel (TP-F) of six Testing Personnel (TP-A, B, C, D, E, and F) received the appropriate training and had demonstrated that they could perform all testing operations reliably to provide and report accurate results for Histopathology testing. Findings included: 1. The CMS-209 Laboratory Personnel Report signed and dated by the Laboratory Director on 10/18 /2025 listed six Testing Personnel (TP-A, B, C, D, E, and F). TP-A was the Laboratory Director. 2. The Daily Log dated 12/03/24, documented the first testing date at this laboratory by TP-F. 3. The laboratory policy and procedure manual last reviewed by the Laboratory Director on 10/18/2025 included a Competency Assessment Procedure which stated new personnel must demonstrate competency prior to reporting patient result and at 6 months. 4. No documentation of appropriate training and demonstration that TP-F could perform all testing operations reliably in this laboratory prior to patient testing and at 6 months. 5. The Laboratory Director confirmed on 10/23/2025 at 11:56 a.m. that there were no training prior to testing patients' specimens or initial and 6 month competency documentation for TP-F.