Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D1100590	04/09/2025
Name of Provider or Supplier	**Street Address, City, State**	
Dermatology Consultants Pa	12600 Pembroke Rd Ste 310, Miramar, 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 DERMATOLOGY CONSULTANTS PA from April 4, 2025 to April 9, 2025. The laboratory is not in compliance with 42 CFR Part 493, Requirements for Laboratories. The following is a description of the standard level deficiencies:
D3029	RETENTION REQUIREMENTS CFR(s): 493.1105(a)(2) Test procedures. Retain a copy of each test procedure for at least 2 years after a procedure has been discontinued. Each test procedure must include the dates of initial use and discontinuance. This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory failed to provide documentation of their quarterly quality system assessment (QA) logs for July and October 2023, and the laboratory failed to provide documentation for the laboratory procedure manual for at least from July 2023 through June 2024. Findings included: 1- Review of the quarterly QA logs revealed no documentation for Quarterly Safety Equipment Monitoring and Quarterly Risk Management Case Review Form for July 2023 and October 2023. 2-Review of the Laboratory Procedure Manual revealed there was no procedure manual onsite for the period reviewed July 2023 through June 2024. There was a laboratory procedure onsite for July 2024 through April 4, 2025. 3- Review of the Quality Assurance procedure revealed in step 8. Record Retention: All routine laboratory records are kept for two years. 4- During an interview exit-call on 04/09/2025 at approximately 3:05 PM, the office manager of the Risk Management consulting firm stated that the laboratory did not find the quarterly records for July 2023 and October 2023, and also did not find a laboratory procedure manual prior to June 2024.
D5601	HISTOPATHOLOGY

	CFR(s): 493.1273(a)(f) (a) As specified in 493.1256(e)(3), fluorescent and immunohistochemical stains must be checked for positive and negative reactivity each time of use. For all other differential or special stains, a control slide of known reactivity must be stained with each patient slide or group of patient slides. Reactions of the control slide with each special stain must be documented. This STANDARD is not met as evidenced by: Based on review of Quality Control (QC) records and Risk Management staff interview, the Laboratory failed to follow the laboratory policy for review of the control slide stain quality for one month (November 2023) out of four random months reviewed (November 2023, August 2024, November 2024 and February 2025). The findings included: 1-Review of the CMS-209 form submitted on 04-04-2025 revealed that there are two testing personnel, the Laboratory Director (TP1) and TP2. 2-Review of the daily QC records showed that the documentation had been signed by the technicians for 11/06/2023, 11/14/2023, 11/20/2023, and 11/27/2023. These records were not signed/initialed by the Mohs surgeon. 3-Review of the procedure Hematoxylin & Eosin (H&E) Staining sated in section 4 "VI: CONTROL ...One section of the first case for that day is cut in a separate slide and stained for the Doctor to review before continuing to stain the first case of the day." And also stated in section 5 "V. QUALITY CONTROL A. Each slide is examined by a Doctor and the quality of the cutting and staining are documented daily." 4-Interview on 04/04/2025 at approximately 2:00 PM with the Risk Management consultant, confirmed that the daily QC records were not signed nor initialed by Mohs surgeon or doctor.