

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 10D2116895	(X3) Date Survey Completed 08/10/2026
Name of Provider or Supplier Sun Dermatology	Street Address, City, State 643 N Highway 231, Panama City, 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 Sun Dermatology on 08/04/2026-08/10/2026. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
D5219	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(2) (c)(2) Any test or procedure listed in subpart I of this part for which compatible proficiency testing samples are not offered by a CMS-approved proficiency testing program. This STANDARD is not met as evidenced by: Based on record review and interview, the Laboratory Director (LD) failed to perform twice annual peer review for MOHs testing for one (2024) of two years (2024-2026). Findings include: 1. Review of the "MOHs Lab Policy and Procedure Manual" signed by the LD on 01/05/2026, did not specify a policy to perform biannual peer reviews for MOHs testing. 2. Review of peer reviews for 2025, it was found that only one peer review was performed on 06/16/2025. 3. Interview with the Laboratory Manager on 08/05/2026 at approximately 1:45 PM confirmed only one peer review was completed in 2025. Review of peer reviews with Laboratory Manager confirmed the LD performed biannual reviews in 2024.
D6005	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(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 and interview, the Laboratory Director (LD) failed to establish a policy to be onsite at least once every six months, with at least 4 months between the minimum two on-site visits and documenting the onsite visits during the year 2025 until 08/10/2026. Findings included: 1) Review of the procedure manual signed by the LD on 01/05/2026 revealed that it did not have policy to specify when the LD must be onsite and document the bi-annual visits. 2) During interview on 08/05/2026 at approximately 1:45 PM, the Laboratory Manager (LM) confirmed there was no policy to monitor the LD visits to the laboratory.