Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D2142152	01/22/2026
Name of Provider or Supplier	**Street Address, City, State**	
Advanced Dermatology And Cosmetic Surgery	11474 Sw Village Parkway, Port Saint Lucie, 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 and Cosmetic Surgery on January 22, 2026. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
D3011	FACILITIES CFR(s): 493.1101(d) Safety procedures must be established, accessible, and observed to ensure protection from physical, chemical, biochemical, and electrical hazards, and biohazardous materials. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the laboratory failed to store waste reagents in a nonflammable cabinet and no ventilation system for chemical. Findings Included: 1. On 1/22/2026 at 3:26 PM, two reagent waste containers labeled biohazard and flammable were stored under the laboratory sink cabinet and ventilation system in the lab for XS-3 Xylene. 2. Review of 100% Reagent Alcohol package read, "Hazard statements: Highly flammable liquid and vapor." 3. Review of XS-3 Xylene Substitute package read, "Hazard statements: Highly flammable liquid and vapor. Store in a dry, cool place. Keep/Store away from direct sunlight, extremely high or low temperatures and incompatible materials. Store in a well-ventilated place. Keep container tightly closed. Keep in fireproof place. Incompatible Materials: Strong acids, strong bases, strong oxidizers. Exposure Controls-Personal Protective Equipment: Gloves. Protective clothing. Protective goggles. Insufficient ventilation: wear respiratory protection." 4. On 1/22/2026 at 5:37 PM, the Office Manager confirmed stored waste reagents were in a flammable cabinet and no ventilation system for XS-3 Xylene.
D5209	PERSONNEL COMPETENCY ASSESSMENT POLICIES CFR(s): 493.1235

	As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency. This STANDARD is not met as evidenced by: Based on record review and interview, the laboratory failed to perform annual competency assessments for 1 out of 6 Testing Personnel in 2025, (Testing Personnel B). Findings Included: 1. Review of Competency Assessments for Testing Personnel effective date September 1, 2014, signed by the laboratory director on 8/27/2025 read, "Mohs Surgeon of Dermatology that perform testing participate in competency assessments upon hire, at 6 months, and annually by attesting to their education." 2. Review of Annual competency assessments for 6 Testing Personnel revealed Testing Personnel B had no documentation of annual competency assessment in 2025. 3. On 1/22/2026 at 5:37 PM, the Office Manager confirmed they failed to perform annual competency assessments for Testing personnel B) in 2025.
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 Potassium Hydroxide (KOH) and scabies testing twice annually in 2024 and 1 out of 2 events in 2025. Findings Included: 1. Review of laboratory personnel report revealed the following: Testing Personnel E and Testing Personnel F were performing KOH and Scabies Testing. 2. Review of bi-annual KOH and/or Scabies and proficiency testing for laboratory testing personnel revealed the following: a. Testing Personnel E had no documentation of KOH and Scabies testing accuracy for 2 out of 2 events in 2024 and 1 out of 2 events in 2025. b. Testing Personnel F had no documentation of KOH and Scabies testing accuracy for 2 out of 2 events in 2024 and 1 out of 2 events in 2025. 3. Review of verification of PPM Test Results effective date on June 2017 signed by the Laboratory Director on 11/20/2025 read, "parasitology and KOH Twice a year, the Testing Personnel will select a patient from whom to collect a specimen for competency and proficiency testing." 4. On 1/22/2026 at 5:37 PM, the Office Manager confirmed they failed to verify accuracy of KOH and scabies testing twice annually in 2024 and 1 out of 2 events in 2025.
D5429	MAINTENANCE AND FUNCTION CHECKS CFR(s): 493.1254(a)(1) (a)(1) Maintenance as defined by the manufacturer and with at least the frequency specified by the manufacturer. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the laboratory failed to perform preventative maintenance for cryostat in 2025. Findings included: 1. On 1/22/2026 at 3:26 PM, Cryostat had a preventive maintenance (PM) done on 12/20/2026 and due

	date for PM on 12/2025. 2. Review of Cryostat Preventive Maintenance revealed no documentation of preventive maintenance for Cryostat in 2025. 3. Review of Equipment Management Laboratory signed by the Laboratory Director on 3/28/2024 read, "Laboratory will ensure that manufacturer's procedures are followed in the maintenance of laboratory equipment. Maintenance will be utilized and maintained on site." 4. On 1/22/2026 at 5:37 PM, the Office Manager confirmed failure to perform preventative maintenance for cryostat in 2025.
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 record review and interview, the laboratory failed to perform reactive control slide for 1 out 5 patients reviewed for Hematoxylin and Eosin (H&E) staining for Mohs surgery, (Patient #1). Findings Included: 1. Review of Patient Reports revealed the following: a. Patient 1 was tested on 4/18/2024 for H&E staining for Mohs surgery. 2. Review of 2024 Quality Control slide: Routine Stain H&E revealed no H&E control slides on 4/18/2024. 3. Review of Quality Control Maintenance signed by the Laboratory Director on 9/30/2024 read, "the stains and reagents must be filtered daily and changed weekly following CP-L 2013 Daily Histology Stain control policy and procedures." 4. On 1/22/2026 at 5:37 PM, the Office Manager confirmed failure to perform a reactive control slide for 1 out 5 patients reviewed for Hematoxylin and Eosin (H&E) staining for Mohs surgery.