Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D2232301	08/27/2026
Name of Provider or Supplier	**Street Address, City, State**	
Advanced Gastroenterolgy Of Central Florida	809 E Oak Street Suite 201, Kissimmee, 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 Gastroenterology of Central Florida on August 27, 2026. The laboratory was surveyed under 42 CFR Part 493 CLIA requirements. Standard deficiencies cited are as follows:
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 document the acceptability of the Helicobacter pylori (H pylori) immunohistochemical negative control slides from 8/5/2024 to 8/27/26. Findings: 1. Review of the procedure titled Daily Quality Control for Histology Slides (signed and dated by the Laboratory Director on 3/3/25) stated, "Immunohistochemical stains will include a positive and negative control with the case for review." 2. Review of the Daily Quality Control Log showed the previous Laboratory Director failed to document the acceptability of the negative control H pylori stained control slides form 8/5/2024 to 2/27/25. 3. Review of the Daily Quality Control Log showed the current Laboratory Director failed to document the acceptability of the negative control H pylori stained control slides form 3/4/25 to 8/27/26. 4. During an interview on 8/27/26 at 11:43 AM, the Laboratory Director acknowledged the acceptability of the negative H pylori control slides was not documented.
D5805	TEST REPORT

	CFR(s): 493.1291(c) (c) The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability. This STANDARD is not met as evidenced by: Based on review of the pathology reports and interview, the laboratory failed to list a code for where the digital histopathology slides were interpreted for three of three (#1 - #3) patient reports. Finding: 1. Review of pathology final reports showed patient reports listed the name and address of the laboratory but did not list a code for where the digital pathology slides were interpreted. 2. Review of the procedure manual (signed and dated by the Laboratory Director on 3/3/25) revealed there was no procedure listing the location of code. 3. During an interview on 8/27/26 at 11:41 AM, the Laboratory Director acknowledged there was no code on the pathology reports and there was no procedure listing the location of code.
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 visit and document at least two onsite visits annually from 3/3/25 to 8/27/26. Findings: 1. Review of the Center for Medicaid and Medicare Services website noted the Laboratory Director became the Laboratory Director on 3/3/25. 2. Review of quality control and quality assurance documents revealed, there was no documentation of onsite visits. 3. During an interview on 8/27/26 at 11:41 AM, the Laboratory Director stated she had not visited the laboratory.