Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D2232915	03/19/2026
Name of Provider or Supplier	**Street Address, City, State**	
J Matthew Knight Md Pa	1901 Lee Road, Winter 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 Forefront Dermatology SC Corp dba Knight Dermatology a Forefront Dermatology Practice on March 19, 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 review of the Safety Data Sheets (SDS) and interview, the laboratory failed to ensure protection from chemical hazards used in their Hematoxylin and Eosin (H&E) stain from 01/18/2024 to 09/19/2026. Findings Included: 1. Review of the SDS for Avantik Acid Alcohol, 1% noted, "Do not dispose of in the drain" 2. Review of the Avantik Reagent Alcohol 95% and Avantik Reagent Alcohol, 100% noted, "Do not allow into any sewer, on the ground, or into any body of water. Avoid release into the environment." During an interview on 03/19/2026 at 9:20 AM, the Mohs technician revealed she dumped the Acidic Acid and the 95% and 100% Reagent Alcohol down the drain.
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 review of the procedure manual, record review, and interview, the laboratory failed to verify accuracy of the reading and interpretation (proficiency testing) of the Hematoxylin and Eosin (H&E) stain for two (Laboratory Director, Testing Personnel D) of four (Laboratory Director, Testing Personnel B - D) Mohs surgeons who performed Mohs surgical procedures in 2024. Findings included: 1. Review of the policy titled Quality Assessment Program - Mohs Laboratory, And dated by the Laboratory Director on 01/01/2026 noted, for proficiency testing "three cases Mohs peer reviewed semi-annually." 2, Review of the Mohs Patient Assession logs showed the Laboratory Director performed Mohs surgical procedures form 03/19 /2024 to 11/4/2024. 3. Review of the Mohs Patient Assession logs showed Testing Personnel D performed Mohs surgical procedures from 10/16/2024 to 11/13/2024. 4. Review of the proficiency testing records revealed there were no records available for review for the Laboratory Director and Testing Personnel D for 2024. 5. During an interview on 03/19/2026 at 11:10 AM, the Practice Manager stated there was no peer review done in 2024 for Laboratory Director. 6. During an interview on 03/19/2026 at 11:35 AM, the Practice Manager stated there was no peer review done in 2024 for Testing Personnel D.
D5413	TEST SYSTEMS, EQUIPMENT, INSTRUMENTS, REAGENT CFR(s): 493.1252(b) (b) The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (b)(1) Water quality. (b)(2) Temperature. (b)(3) Humidity. (b)(4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This STANDARD is not met as evidenced by: Based on review of the procedure manual, record review, and interview, the laboratory failed to document the room temperature for 75 of 121 days that Mohs surgical procedures were performed in 2025. Findings included: 1. Review of the procedure titled, Lab Thermometer Maintenance, signed and dated by the Laboratory Director on 01/01/2026 noted, "Document that thermometer check has been completed by initialing Log 722-B Room Temp/ Humidity Chart." 2. Review of the Room Temp/Humidity log noted, "The room temperature and humidity will be checked at the beginning of each work day, when cryostat in use." 3. Review of the Room Temp/Humidity log showed the room temperatures were not recoreded on the following days in 2025: January - 6, 7, 8, 9, 10, 20, 21, 22, 23, 24 February - 3, 4, 5, 6, 7, 17, 18, 19, 20, 21 March - 3, 4, 5, 6, 7, 19, 20, 21, 24, 25, 26, 31 April - 1, 2, 3, 4, 14, 15, 16 17, 18, 20, 21 May - 6, 7, 19, 20, 21, 22, 23 June - 2, 3, 4, 5, 6, 16 17, 18, 30 July - 1, 2, 3, 14, 15, 16 17, 18, 28, 29, 30 August - 11, 12, 13, 14, 15 4. Review of the Clinical Laboratory Amendments Application for Certification signed and dated by the Laboratory Director on 03/16/2026, reported a total estimated annual test volume of 1,000. 5. During an interview on 03/19/2026 at 10:17 PM, the Practice Manager acknowledged room temperatures were not recorded.
D6120	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(7)(8)

	(b)(7) Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed; (b)(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. This STANDARD is not met as evidenced by: Based on review of the procedure manual, review of personnel records, and interview, the Technical Supervisor (Laboratory Director) failed to document competency evaluation for one (Testing Personnel B) of two (Laboratory Director and Testing Personnel B) Mohs Surgeons in 2024 and 2025, and failed to document the initial training / competency evaluation for two (Testing Personnel C - D) of four Mohs Surgeons (Laboratory Director and Testing Personnel B - D) in 2024. Findings included: 1. Review of the procedure titled, Personnel Competency Testing, signed and dated by the Laboratory Director on 01/01/2026 noted, "Laboratory compliance requires training/competency to be completed initially, 6 months after the start date and annually thereafter." 2. Review of the personnel records for Testing Personnel B revealed there was no documentation of annual competency evaluations on the Mohs Surgeon for 2024 and 2025. 3. Review of the personnel records for Testing Personnel C and D revealed there was no documentation of initial training / competency evaluation for the Mohs Surgeons for 2024. 4. During an interview on 03/99/2026 at 12:05 PM, the Practice Manager stated she did not think there was any competency evaluation on the Mohs Surgeons.