Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	10D2315134	06/11/2025
Name of Provider or Supplier	**Street Address, City, State**	
South Florida Dermatology Group Inc	12600 Sw 120 St Suite #113, Miami, 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 initial survey was conducted at South Florida Dermatology Group INC on June 4, 2025 to June 11, 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:
D5293	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(b)(c) (b) The general laboratory systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of general laboratory systems quality assessment reviews with appropriate staff. (c) The laboratory must document all general laboratory systems quality assessment activities. This STANDARD is not met as evidenced by: Based on record review and staff interview, the Laboratory failed to follow the Quality Assessment (QA) policy for the monthly QA activities in the MOHS laboratory for four (February, March, April, May) out of five months (January, February, March, April, May) reviewed in 2025. Findings included: 1- Review of the Quality Assessment Plan, stated in section "VI. QUALITY CONTROL ASSESSMENT" that the "Laboratory Director will review all quality control charts and logs on at least a monthly basis." 2- Review of the Monthly Patient QA checklist dated 02/11/2025, 03/11/2025, 04/29/2025, and 05/13/2025 were signed and dated by the Technician, but were not signed by the Laboratory Director. 3- Review of the Monthly QA Checklists dated 02/25/2025, 03/25/2025, 04/29/2025, and 05/27/2025 were signed and dated by the Technician, but were not signed by the Laboratory Director. 4- During an interview on 06/04/2025 at 1:45 PM the Risk Management Consultant confirmed that the checklists were not signed by the Laboratory Director.
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 Patient reports and Risk Management Consultant interview, the Laboratory failed to include the name of the Laboratory that performed the Histology interpretation test on 4 out of 4 (Patients #1, #2, #3, and #4) reports reviewed. Findings included: 1- Review of random patient final report pulled 01/07/20025 (#1), 02/11/2025 (#2), 03/25/2025 (#3), and 05/13/2025 (#4) revealed that all four reports failed to spell out the laboratory that performed the Histological Technical and Professional Component. 2- During an interview on 06/04/2025 at 12:45 PM the Risk Management Consultant confirmed that the Laboratory name was not spelled out on the final reports.