Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	11D0682811	06/17/2026
Name of Provider or Supplier	**Street Address, City, State**	
William E Freeman Md	136 S Houston Lake Dr, Warner Robins, GA	

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	A Clinical Laboratory Improvement Amendments (CLIA) recertification survey was completed on June 17, 2026. The laboratory was not in compliance with applicable CLIA requirements found at 42 CFR 493.1 through 42 CFR 493.1780. The following deficiencies were cited:
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 Quality Assessment (QA) document review and staff interview, the laboratory failed to document ALL quality assessment activities on a monthly basis as stated in the QA policy manual from June 2024 through June 17, 2026. Findings: 1. A review of the laboratory QA documents revealed the technical supervisor (TS), who is also the laboratory director, failed to review and sign monthly quality activity checklists and maintenance logs from June 2024 through June 17, 2026. 2. A review of daily maintenance logs, including Room Temperature (RT), humidity, eye wash, cryostat, refrigerator, thermoscientific stainer and microscope maintenance logs, were not reviewed and signed by the laboratory director from June 2024 through June 17, 2026. 3. An interview with the office manager , on 06/17/2026, at approximately 12: 35 PM, in the break room confirmed the above laboratory logs and QA checklists were not reviewed and signed by the laboratory director from June 2024 through June 17, 2026.
D5403	PROCEDURE MANUAL

	CFR(s): 493.1251(b) (b) The procedure manual must include the following when applicable to the test procedure: (b)(1) Requirements for patient preparation; specimen collection, labeling, storage, preservation, transportation, processing, and referral; and criteria for specimen acceptability and rejection as described in 493.1242. (b)(2) Microscopic examination, including the detection of inadequately prepared slides. (b)(3) Step-by-step performance of the procedure, including test calculations and interpretation of results. (b)(4) Preparation of slides, solutions, calibrators, controls, reagents, stains, and other materials used in testing. (b)(5) Calibration and calibration verification procedures. (b)(6) The reportable range for test results for the test system as established or verified in 493.1253. (b)(7) Control procedures. (b)(8) Corrective action to take when calibration or control results fail to meet the laboratory's criteria for acceptability. (b)(9) Limitations in the test methodology, including interfering substances. (b)(10) Reference intervals (normal values). (b)(11) Imminently life-threatening test results, or panic or alert values. (b)(12) Pertinent literature references. (b)(13) The laboratory's system for entering results in the patient record and reporting patient results including, when appropriate, the protocol for reporting imminently life threatening results, or panic, or alert values. (b)(14) Description of the course of action to take if a test system becomes inoperable. This STANDARD is not met as evidenced by: Based on a review of the Standard Operating Procedures and staff interview, confirmed that the laboratory failed to establish and make available ALL policies and procedures for testing personnel in the procedure manual as of June 17, 2026. Findings: 1. A review of the Standard Operating Procedures revealed that the laboratory failed to establish and make available a downtime policy/ procedure for testing equipments in the laboratory. 2. A procedure for specimen handling and transportation to and from reference and other laboratories was not available on day of survey, June 17, 2026. 3. A procedure for critical values alert was not available for testing personnel as of day of survey, June 17, 2026. 4. An interview with the office manager, in the break room, on 06/17/2026, at approximately 12:30 PM confirmed the aformentioned policy and procedures were not available for testing personnel on the date of survey, June 17, 2026.
D5417	TEST SYSTEMS, EQUIPMENT, INSTRUMENTS, REAGENT CFR(s): 493.1252(d) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality. This STANDARD is not met as evidenced by: Based on review during the laboratory tour and staff interview, several lots of tissue dye used in the laboratory had exceeded their expiration dates, as observed on the day of survey , June 17, 2026. Findings: 1. A review of tissue dye reagents, on the second floor laboratory, revealed the following expired tissue dye(s): - Red dye lot # 159204 expired - 10/31/2024. - Violet dye lot # 097215 expired - 02/28/2022. - Yellow dye lot # 043215 expired - December 2017. - Green dye lot # 043216 expired - November 2017. 2. All expired dye(s) were immediately discarded in the lab's bioharzard sharps container by surveyor. 3. An interview with the office manager on Jun 17, 2026, in the

	second floor Mohs laboratory, at approximately 10:15 AM, confirmed the aformentioned tissue dye(s) in use were expired as of the day of survey June 17, 2026
D6004	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(a)(b) The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, and record and report test results promptly, accurate, and proficiently and for assuring compliance with the applicable regulations. (a) The laboratory director, if qualified, may perform the duties of the technical consultant, clinical consultant, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications of 493.1409, 493.1415, and 493.1421, respectively. (b) If the laboratory director reapportions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed. This STANDARD is not met as evidenced by: Based on documents review and and staff interview, the laboratory director failed to ensure that all phases of quality testing (preanalytic, analytic and post analytic) guidelines were followed to identify and fix problems in the laboratory from June 2024 - June 2026 as required by Clinical Laboratory Improvement Amendments (CLIA). Findings: 1. (QA) documents review revealed the laboratory director, who is also the technical supervisor (TS), failed to review and ensure that ALL monthly Quality Assurance (QA) guidelines were followed to identify and fix problems in the laboratory from June 2024 - June 17, 2026. 2. An interview with the office manager in the break room on June 17, 2026, at approximately 12:35 PM, confirmed the laboratory director failed to ensure proper oversight of the laboratory from June 2024 - June 17, 2026.