Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	11D0724381	06/04/2026
Name of Provider or Supplier	**Street Address, City, State**	
Atlanta West Dermatology Pc	1550 Mulkey Road, Austell, 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 04, 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:
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 personnel records review and interview with laboratory staff, the laboratory director failed to ensure that annual competencies for testing personnel (TP) including mid level practitioners performing laboratory tasks were performed according to CLIA criteria in May 2024 thru June 2026. Findings: 1. A review of competency assessment records revealed that TPs (#2 thru #6) (CMS-209) had no annual competency assessments records from May 2024 thru June 2026. 2. There were no peer review records for KOH preps available for TPs (#2 thru #6) (CMS 209) twice annually from May 2024 thru June 2026. 3. An interview, with the laboratory staff, in the review room, at approximately 12:10 PM, on 06/04/2026, confirmed there were no annual competencies for TPs (#2 tthru #6) (CMS -209) from May 2024 thru June 2026.
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 their QA policy manual from May 2024 through June 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 May 2024 through June 2026. 2. A review of daily maintenance logs including: Room Temperature(RT), humidity, eye wash, refrigerator, cryostat cleaning and stainer logs were not reviewed or signed by the laboratory director from May 2024 through June 2026. 3. An interviews with laboratory staff, on 06/04/2026, at approximately 12:35 PM, in the break room, confirmed the above laboratory logs and QA checklists were not reviewed or signed by the laboratory director from May 2024 through June 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 interview with laboratory staff, 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 May 2024 thru June 2026 as required by The Clinical Laboratory Improvement Amendments (CLIA). Findings: 1. (QA) documents review revealed the lab director, who is also the technical supervisor (TS), failed to provide laboratory oversite of the lab by reviewing and adhering to ALL monthly Quality Assurance (QA) guidelines to identify and fix problems in the laboratory from May 2024 thru June 2026. 2. An interview with the laboratory coordinator, in the break review room, on 06/04/2026, at approximately 12:40 PM, confirmed that the lab director failed to ensure oversight of the laboratory from May 2024 through June 2026.