Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	11D0891572	03/17/2026
Name of Provider or Supplier	**Street Address, City, State**	
Sgpa - Hematology And Oncology 6450 (B)	2500 Starling Street, Suite 303, Brunswick, 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 March 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:
D6079	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(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, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations. (a) The laboratory director, if qualified, may perform the duties of the technical supervisor, clinical consultant, general supervisor, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications under 493.1447, 493.1453, 493.1459, and 493.1487 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: A review of the current Laboratory Procedure Manual, 2024 - 2026 Maintenance Records, 2024 - 2026 Personnel Records, 2024 - 2026 Proficiency Testing Records, 2024 - 2026 Quality Assurance Records, 2024 - 2026 Quality Control Records, and 2024 - 2026 Temperature Records confirmed that the Laboratory Director failed to provide proper oversight of the overall operations and administrations of the facility to assure accurate and quality results. THE FINDINGS INCLUDE: 1. A review of the 2024 - 2026 Personnel Records revealed that Testing Personnel 1 (TP1) (identified on CMS-Form 209) performed the competencies on Testing Personnel 2 (TP2) (identified on CMS-Form 209.) 2. A review of 2024 - 2026 Quality Assurance Records confirmed that quality assurance oversight was performed by TP1. 3. A review of the

	2024 - 2026 Personnel Records revealed that a written Letter of Delegation, from the Laboratory Director, assigning duties performed by TP1, was not available on the day of survey. 4. An exit interview, with Testing Personnel 1, on March 17, 2026, at 2: 30pm, confirmed that the Laboratory Director failed to provide proper oversight of the overall operations of the laboratory to assure accurate and quality clinical laboratory results.