Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	11D1020334	02/28/2020
Name of Provider or Supplier	**Street Address, City, State**	
Kayal Dermatology And Skin Cancer	141 Lacy Street, Suite 200, Marietta, 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 February 28, 2020. 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:
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 observation and staff interview, the laboratory failed to observe safety procedures to ensure protection from physical, chemical, and electrical hazards as required. Findings include: 1. Observation during the laboratory tour and subsequent office tour on 2/28/2020 at approximately 11:30 a.m. revealed all three fire extinguishers in the facility were last inspected on 9/06/2017. 2. An interview with the lead histotech in the laboratory on 2/28/2020 at approximately 11:45 a.m. confirmed al three fire extinguishers in the facility were last inspected on 9/06/2017.
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 testing personnel (TP) document review and staff interview, the laboratory

	failed to verify twice annually the accuracy of any unregulated test or procedure it performs as required. Findings include: 1. Based on TP document review, the laboratory failed to have available at the time of survey 2018 twice annual peer review documents for Staff #5 (CMS 209). 2. An interview with the lead histotech in the laboratory on 2/28/2020 at approximately 11:45 a.m. confirmed the lack of 2018 twice annual peer reviews for Staff #5 (CMS 209).