

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 11D2085521	(X3) Date Survey Completed 09/08/2026
Name of Provider or Supplier Fayette Area Dermatology	Street Address, City, State 731 South 8th Street, Griffin, 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 September 8, 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:
D5791	ANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1289(a)(c) (a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and when indicated, correct problems identified in the analytic systems specified in 493.1251 through 493.1283. This STANDARD is not met as evidenced by: Based on review of the standard operating procedure (SOP), Quality Assurance logs for 2025 and 2026, and interview with testing personnel, the laboratory failed to follow its established procedure for monitoring and documenting room temperature daily. Findings: 1. Review of the SOP revealed that room temperature was required to be monitored and documented daily as part of the Quality Assurance process. Review of the Quality Assurance logs for 2025 and 2026 revealed that room temperature was not documented daily. 2. During an interview with the Clinical Team Lead on September 8, 2026, at 12:00 PM, in the facility break room, the Clinical Team Lead confirmed that room temperature was recorded on days when Mohs surgery was performed and not daily in accordance with the established policy and procedure.
D6128	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(9) (b)(9) Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individuals performance must be reevaluated to include the use of the new

test methodology or instrumentation.

This STANDARD is not met as evidenced by:

Based on review of personnel records and interview with the Clinical Team Lead, the Laboratory Director failed to ensure annual competency assessments were documented for all Testing Personnel (TP). Findings: 1. Review of Testing Personnel records revealed that 1 of 1 testing personnel did not have documented annual competency assessments completed for 2025 and 2026. 2. During an interview with the Clinical Manager and the Clinical Team Lead in the conference room on September 08, 2026, at 12:00 p.m., it was confirmed that annual competency assessments for TP 1 (CMS-209) had not been performed during for the years 2025 and 2026.