

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  11D2095067	<b>(X3) Date Survey Completed</b>  01/13/2026
<b>Name of Provider or Supplier</b>  Southeast Dermatology Specialists	<b>Street Address, City, State</b>  4645 Timber Ridge Drive Suite 100, Douglasville, GA	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>
<b>D0000</b>	A Clinical Laboratory Improvement Amendments (CLIA) recertification survey was completed on January 13, 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:
<b>D5293</b>	<p><b>GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT</b> CFR(s): 493.1239(b)(c)</p> <p>(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.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the Histopathology Standard Operating Procedure (SOP), Quality Control (QC) document review, and staff interview, the laboratory failed to document corrective actions or quality assessment monitoring activities for the pre-analytic, analytic, and post-analytic phases of testing for years 2024 and 2025. Findings: 1. A review of the SOP and QC documents revealed that the laboratory did not include documented corrective actions or documented evidence of quality assessment monitoring during the time period of 2024 or 2025. 2. An interview, conducted with the Clinical Manager, in the MOHS laboratory, on January 13, 2026, at 12:32 p.m. confirmed the aforementioned findings.</p>
<b>D6032</b>	<p><b>LABORATORY DIRECTOR RESPONSIBILITIES</b> CFR(s): 493.1407(e)(14)</p> <p>(e)(14) Specify, in writing, the responsibilities and duties of each consultant and each</p>

person, engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or results reporting, and whether consultant or director review is required prior to reporting patient test results.

This STANDARD is not met as evidenced by:  
Based on review of the laboratory Standard Operating Procedure (SOP) and staff interview, the laboratory director (LD) failed to specify, in writing the duties and responsibilities of Testing Personnel (TP) engaged in the performance of the preanalytic, analytic, and postanalytic phases of laboratory testing. Findings include:  
1. SOP review revealed the LD failed to specify in writing the duties and responsibilities of Testing Personnel. 2. An Interview , in the MOHS laboratory, on January 13, 2026, at 12:32 p.m., with the Clinical Manager confirmed that the SOP did not contain Testing Personnel duties and respnsibilities. .

**D6072**

**TESTING PERSONNEL RESPONSIBILITIES**  
CFR(s): 493.1425(b)(3)

(b)(3) Adhere to the laboratory's quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed;

This STANDARD is not met as evidenced by:  
Based on review of the laboratory's maintenance records and an interview with laboratory staff, the laboratory failed to document required monthly maintenance for the BOND equipment in histopathology lab. Findings: 1.A review of histopathology maintenance logs revealed the laboratory failed to document required maintenance activities from August 2024 through November 2025, maintenance was documented only for Oct. 2025. 2. An interview, conducted with the Clinical Manager, in the MOHS laboratory, on January 13, 2025, at 12:32 PM confirmed the laboratory did not consistently document the required equipment maintenance during the identified timeframes.