Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 11D2107617	**(X3) Date Survey Completed** 01/06/2020
Name of Provider or Supplier Skin Cancer Specialists Pc - Cartersville (Dba)	**Street Address, City, State** 10 Cloverleaf Drive, Cartersville, 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 January 06, 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 an interview with the laboratory manager (TP #8 CMS 209), the laboratory failed to implement and established safety procedure to ensure protection from physical, biochemical, and biohazardous materials. Findings include: 1. During the laboratory tour it was observed that the two fire extinguishers in and around the laboratory area were not inspected annually. Last inspection was July of 2017. 2. An interview with the laboratory manager (TP#8 CMS 209), during the laboratory tour, on 01/06/2020, at approximately 10:25 a.m. confirmed that the fire extinguishers have not been inspected for two and a half (2.5) years.
D5291	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(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 general laboratory systems requirements specified at 493.1231 through 493.1236.

	This STANDARD is not met as evidenced by: A review of the procedure manual and an interview with the laboratory manager (PT#8 CMS 209), revealed that the laboratory failed to have an adequate Quality Assurance (QA) policy specific to the specialty of Histopathology in 2018 and 2019. Findings include: 1.) Procedure manual review revealed that the clinic does not have an adequate (QA) policy specific to the specialty of Histopathology. 2.) An interview with the laboratory manager (TP #8 CMS209), at approximately at 12:30 pm, on 01/06 /2020 in the break room, confirmed that the clinic did not have an adequate written QA policy specific to Histopathology in 2018 and 2019.
D6094	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) The laboratory director must ensure that the quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur. This STANDARD is not met as evidenced by: Based on review of the laboratory's maintenance, Quality Assurance(QA) records and an interview with the laboratory manager(TP#8 CMS 209), the General Supervisor (GS) and the laboratory director failed to ensure that Monthly (QA) reports and maintenance logs were reviewed and signed in 2018 and 2019. Findings include: 1. Maintenance and Quality Assurance report review revealed QA and maintenance logs were not reviewed and signed in 2018 and 2019 by the Technical Supervisor(TS) or the laboratory director. 2. An interview with the laboratory manager (TP#8 CMS 209) on 01/06/ 2020, at approximately 12:40 pm, in the break room confirmed that maintenance logs and QA reports were not reviewed and signed by the (TS) or the laboratory director.