

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 11D2193603	(X3) Date Survey Completed 03/19/2025
Name of Provider or Supplier Southeast Dermatology Specialists	Street Address, City, State 100 Market Place Boulevard, Suite 300, 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 March 19, 2025. 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:
D5219	<p>EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(2)</p> <p>(c)(2) Any test or procedure listed in subpart I of this part for which compatible proficiency testing samples are not offered by a CMS-approved proficiency testing program.</p> <p>This STANDARD is not met as evidenced by: Based on Peer Review document review and staff interview, the laboratory failed to verify at least twice annually the accuracy of any test or procedure performed Findings: 1. Peer Review document review revealed twice annually peer reviews were not performed for MOHS Micrographic Surgery/ Histology testing in 2024 to 2025 thus far. 2. Interview with the laboratory coordinator on 03/19/25 at 14:25 p.m. in the breakroom confirmed the lack of peer reviews for the dates indicated above.</p>
D5293	<p>GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT 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>

This STANDARD is not met as evidenced by:
Based on Quality Assessment (QA) document review and staff interview, the laboratory failed to document quality assessment activities on a monthly or quarterly basis per their QA guidelines as required. The Findings include: 1. Laboratory QA documents review revealed the laboratory did not have a monthly or quarterly quality checklist for 2024 thru date of survey (03/19/25). 2. An interview with the laboratory coordinator, on 03/19/25, at 2:45 PM in the breakroom confirmed the lack of an adequate QA checklist review by laboratory director.