

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  14D2044680	<b>(X3) Date Survey Completed</b>  04/23/2026
<b>Name of Provider or Supplier</b>  Summit Dermatology And Aesthetic Surgery	<b>Street Address, City, State</b>  1 S 210 Summit Ave, Oakbrook Terrace, IL	
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>D5473</b>	<p><b>CONTROL PROCEDURES</b> CFR(s): 493.1256(e)(2)(g)</p> <p>(e)(2) Each day of use (unless otherwise specified in this subpart), test staining materials for intended reactivity to ensure predictable staining characteristics. Control materials for both positive and negative reactivity must be included, as appropriate.</p> <p>This STANDARD is not met as evidenced by: Based on review of laboratory policies and procedures, record review, and interview with the laboratory representative; the laboratory failed to perform hematoxylin and eosin (H&amp;E) quality control procedures to ensure intended reactivity, as specified by the laboratory for Mohs Micrographic surgery testing for 31 of 31 days of patient testing starting on 05/17/24 through the date of survey 04/23/26. Findings include: 1. Review of the laboratory's policy and procedure manual identified the procedure titled "Quality control procedure H&amp;E Stain" that stated: "The quality of H&amp;E stain is monitored on every day staining is performed. The technician will stain the first sections of the first specimen of the day to make quality control slide. The Quality control is submitted to the lab director Mohs surgeon for evaluation. Upon evaluation, The lab director will sign and comment on the stain on the H&amp;E stain quality control form." 2. Review of records titled "H&amp;E stain Quality control" revealed the laboratory had failed to document H&amp;E intended reactivity for 31 of 31 days of patient testing starting on 05/17/24 through the date of survey 04/23/26. Dates H&amp;E intended reactivity was not evaluated: 1. 05/17/24 2. 05/21/24 3. 06/28/24 4. 07/20/24 5. 08/14/24 6. 09/28/24 7. 10/10/24 8. 10/16/24 9. 11/09/24 10. 11/20/24 11. 12/13/24 12. 12/27/24 13. 01/11/25 14. 02/22/25 15. 04/18/25 16. 04/22/25 17. 05/27/25 18. 06/21/25 19. 07/22/25 20. 07/29/25 21. 09/02/25 22. 10/04/25 23. 10/14/25 24. 10/21/25 25. 11/18/25 26. 12/10/25 27. 01/06/26 28. 01/28/26 29. 02/11/26 30. 03/11/26 31. 04/08/26 3. An interview with laboratory representative at 10:26 am, on 04/23/26, confirmed the laboratory failed to document intended reactivity for H&amp;E staining starting on 05/17/24 until the date of survey. 4. Review of records titled "Mohs Micrographic</p>

Surgery" revealed a total of 196 patients were tested on dates without H&E intended reactivity performed.

**D5801**

TEST REPORT  
CFR(s): 493.1291(a)

(a) The laboratory must have an adequate manual or electronic system(s) in place to ensure test results and other patient-specific data are accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to final report destination, in a timely manner. This includes the following: (a)(1) Results reported from calculated data. (a)(2) Results and patient-specific data electronically reported to network or interfaced systems. (a)(3) Manually transcribed or electronically transmitted results and patient-specific information reported directly or upon receipt from outside referral laboratories, satellite or point-of-care testing locations.

This STANDARD is not met as evidenced by:  
Based on review of laboratory patient log, test reports and interviews with the laboratory representative; the laboratory failed to have a reliable system to ensure that manually transcribed test results are accurately transferred to the final report destination for one of six Mohs micrographic surgery patient test reports reviewed. Findings include: 1. Review of laboratory patient test log titled "Mohs micrographic surgery" revealed that patient 1995146 had two stages of Mohs micrographic surgery performed on 12/10/25. 2. Review of patients Mohs micrographic surgery patient test reports revealed one of six manually transcribed patient test results were not correctly transferred to the patient's final report. Medical record number: Date of Testing: Number of stages reported: 1995149 12/10/25 1 3. Interviews with the laboratory representative at 11:15 am, on 04/23/26, confirmed that the laboratory failed to correctly document the number of stages in the patient's final report for the patient identified above.