Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	14D2261543	06/22/2026
Name of Provider or Supplier	**Street Address, City, State**	
Dermatology & Aesthetics Of Wicker Park Pllc	1733 N Harlem Ave, Chicago, IL	

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 recertification survey was conducted on 06/22/2026. The laboratory was found to be out of compliance with the CLIA regulations (42 CFR Part 493) for the following condition-level deficiencies: D5200 - 42 C.F.R. 493.1230 Condition: General laboratory systems.
D5200	GENERAL LABORATORY SYSTEMS CFR(s): 493.1230 Each laboratory that performs nonwaived testing must meet the applicable general laboratory systems requirements in 493.1231 through 493.1236, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the general laboratory systems and correct identified problems specified in 493.1239 for each specialty and subspecialty of testing performed. This CONDITION is not met as evidenced by: Based on review of laboratory policies and procedures, laboratory records, the Plan of Correction (PoC) response from the 01/25/2025 certification survey, lack of documentation, and interviews with the laboratory representative; the laboratory failed to perform bi-annual method accuracy evaluations for microscopic Potassium Hydroxide (KOH) wet mount testing and Mohs micrographic surgery testing in 2025 (see D5217), failed to evaluate results of bi-annual method accuracy for three of three Mohs micrographic surgery events reviewed (see D5221), and failed to follow the written quality assurance policy for monitoring, assessing, and correcting problems for 5 of 17 months reviewed (see D5291) from the beginning of 2025 through the date of survey, 06/22/2026.
D5217	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(c)(1)

	At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part. This STANDARD is not met as evidenced by: A) Repeat Deficiency from 01/24/2025 survey. Based on review of laboratory policies and procedures, laboratory records, the Plan of Correction (PoC) response from the 01/25/2025 certification survey, lack of documentation, and interview with the laboratory representative; the laboratory failed to perform bi-annual method accuracy evaluations for microscopic Potassium Hydroxide (KOH) wet mount testing in 2025. Findings include: 1. Review of laboratory policies and procedures revealed the policy titled, "MYCOLOGY", which stated, "This lab has joined a proficiency testing program with The American Proficiency Testing Institute [API]. Membership receipt attached. This lab will have reviews done at least bi-annually. Results will be documented in manuals." 2. Review of laboratory records found no documented API membership receipt. 3. Review of the PoC response from the 01/25/2025 certification survey, received 02/07/2025, revealed the procedure titled "KOH Proficiency Testing", which stated, "Providers are required to complete bi-annual KOH proficiency testing to maintain documentation of proficiency." This procedure was still present within the laboratory's policies and procedures upon the date of survey, 06/22/2026. 4. Review of laboratory records revealed the laboratory failed to verify the accuracy of KOH wet mount testing twice annually in 2025. 5. Interview with the laboratory representative on 06/22/2026, at 3:11 pm, confirmed the laboratory failed to perform bi-annual method accuracy evaluations for microscopic KOH wet mount testing in 2025. B) Based on review of laboratory policies and procedures, laboratory records, and interview with the laboratory representative; the laboratory failed to perform bi-annual method accuracy (proficiency testing/peer reviewed Mohs micrographic surgery results) for histopathology testing in 2025. Findings include: 1. Review of laboratory policies and procedures revealed the procedure titled "Proficiency Testing [-] Mohs Micrographic Surgery Skin Specimens", which stated, "Semi-annually, the tech or Risk Manager will send two cases containing the original slides, label it with only the surgical case number, and send it ou[t] for a microscopic examination by a Board Certified Dermatopathologist." 2. Review of laboratory records revealed the laboratory failed to perform bi-annual method accuracy (proficiency testing/peer reviewed Mohs micrographic surgery results) for histopathology testing in 2025. Dates of testing reviewed: Date review mailed: January, 2025 - June, 2025 06/16/2026 July, 2025 - December, 2025 06/16/2026 3. Interview with the laboratory representative on 06/22/2026, at 3:11 pm, confirmed the laboratory failed to perform bi-annual method accuracy (proficiency testing/peer reviewed Mohs micrographic surgery results) for histopathology testing in 2025.
D5221	EVALUATION OF PROFICIENCY TESTING PERFORMANCE CFR(s): 493.1236(d) All proficiency testing evaluation and verification activities must be documented. This STANDARD is not met as evidenced by: Based on review of laboratory policies and procedures, laboratory records, lack of documentation, and interview with the laboratory representative; the laboratory failed to evaluate results of bi-annual method accuracy (proficiency testing/peer reviewed Mohs micrographic surgery results) for three of three events reviewed from July, 2024 through the date of survey, 06/22/2026. Findings include: 1. Review of laboratory

	policies and procedures revealed the procedure titled "Proficiency Testing [-] Mohs Micrographic Surgery Skin Specimens", which stated, "Upon receipt of the pathology report from the Dermatopathologist, [result] of the slide specimen will be matched to the in-house [result] by the physician." 2. Review of laboratory records revealed the laboratory failed to evaluate peer reviewed Mohs micrographic surgery results for three of three events reviewed: Dates of testing reviewed: Date review returned: July, 2024 - December, 2024 01/21/2025 January, 2025 - June, 2025 06/18/2026* July, 2025 - December, 2025 06/18/2026* *see D5217b 3. Interview with the laboratory representative on 06/22/2026, at 1:23 pm, confirmed the laboratory failed to evaluate results of bi-annual method accuracy (proficiency testing/peer reviewed Mohs micrographic surgery results) for three of three events reviewed from July, 2024 through the date of survey, 06/22/2026.
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: Based on review of laboratory policies and procedures, laboratory records, lack of documentation, and interview with the laboratory representative; the laboratory failed to follow the written quality assurance policy for monitoring, assessing, and correcting problems for 5 of 17 months reviewed from the beginning of 2025 through the date of survey, 06/22/2026. Findings include: 1. Review of laboratory policies and procedures revealed the policy titled "Quality Assurance", which stated, "Monthly the nurse or tech will check off the Monthly Quality Assurance Checklist." 2. Review of laboratory records revealed the laboratory lacked documentation of monthly quality assurance checks for the following 5 of 17 months reviewed: December, 2025 January, 2026 March, 2026 April, 2026 May, 2026 3. Interview with the laboratory representative on 06/22/2026, at 3:11 pm, confirmed the laboratory failed to follow the written quality assurance policy for monitoring, assessing, and correcting problems for 5 of 17 months reviewed from the beginning of 2025 through the date of survey, 06/22/2026.
D6120	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(7)(8) (b)(7) Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed; (b)(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. This STANDARD is not met as evidenced by: Based on review of the CMS-209 (Laboratory Personnel Report) Form, laboratory policies and procedures, laboratory records, and interview with the laboratory representative; the technical supervisor (TS) failed to ensure the training and competency for one of one testing personnel (TP) performing histopathology tissue

	grossing was performed prior to patient testing, affecting 19 patients. Findings include: 1. Review of the CMS-209 (Laboratory Personnel Report) Form, signed by the laboratory director on 06/15/2026, identified one TP (TP #4) performing histopathology tissue grossing. 2. Review of laboratory policies and procedures revealed the procedure titled "Competency and CLIA competency assessment", which stated, "Competency assessment, which includes the procedures, must be performed for testing personnel for each test that the individual is approved by the laboratory director to perform." 3. Review of personnel records revealed TP #4 received training for histopathology tissue grossing on 06/01/2026. 4. Review of laboratory records revealed that TP #4 began histopathology tissue grossing of patient specimens on 02 /23/2026 and tested 19 patients prior to documented training on 06/01/2026. 5. Interview with the laboratory representative on 06/22/2026, at 1:23 pm, confirmed the TS failed to ensure the training and competency for one of one TP performing histopathology tissue grossing was performed prior to patient testing, affecting 19 patients.