Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	19D2308152	06/15/2026
Name of Provider or Supplier	**Street Address, City, State**	
Dermatology Clinic - Lake Charles I	1800 Barbe St, Lake Charles, LA	

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 June 15, 2026 at Dermatology Clinic - Lake Charles I - CLIA ID # 19D2308152. The laboratory was found in compliance with 42 CFR 493 Requirement for Laboratories; however, standard level deficiencies were cited.
D6080	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(c) (c) The laboratory director must: (c)(1) Be onsite at least once every 6 months, with at least 4 months between the minimum two on-site visits. Laboratory directors may elect to be on-site more frequently and must continue to be accessible to the laboratory to provide telephone or electronic consultation as needed; and (c)(2) Provide documentation of these visits, including evidence of performing activities that are part of the laboratory director responsibilities. This STANDARD is not met as evidenced by: Based on record review and interview with personnel, the Laboratory Director failed to be onsite at least once every six months with at least four months between the two visits in 2025. Findings: 1. Review of the laboratory's documentation of onsite visits by the Laboratory Director revealed the laboratory did not have documentation of the Laboratory Director being onsite from January 2025 through June 15, 2026. 2. In interview with personnel on June 15, 2026 at 10:47 a.m., the General Supervisor confirmed the Laboratory Director was not onsite at the laboratory as identified above.
D6151	GENERAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1463(b)(3)(4) (b)(3) Providing orientation to all testing personnel; and (b)(4) Evaluating and documenting the competency of all testing personnel.

This STANDARD is not met as evidenced by:
I. Based on review of the laboratory's CMS-209 form (Laboratory Personnel Report) and personnel records and interview with personnel, the General Supervisor failed to document initial training for one (1) of one (1) testing personnel reviewed. Findings: 1. Review of the laboratory's CMS-209 form (Laboratory Personnel Report) revealed the laboratory had the following testing personnel: Testing Personnel 1 (also served as General Supervisor) Testing Personnel 2 2. In interview on June 15, 2026 at 12:11 p. m., the Histology Department Supervisor stated Testing Personnel 2 was hired in October 2025 and training was performed. 3. Review of personnel records for Testing Personnel 2 revealed the following documentation: Testing Personnel 2 "joined our staff remotely in October 2025. He is a Dermatopathologist who will be assisting" Testing Personnel 1 "with the reading of some of our histology slides when needed. Upon joining our team, he was trained on Winsurge via multiple Zoom sessions with Computer Trust. He was also trained on our EMA system Nextech via multiple Zoom sessions." 4. Further review of the personnel records for Personnel 2 revealed the training document did not include who performed the training and/or when the training was performed. 5. Review of competency records for the General Supervisor revealed the General Supervisor had the following delegated responsibility: "Provides orientation to all testing personnel and completes/documents annual evaluations /performance reviews." II. Based on review of the laboratory's policy, CMS-209 (Laboratory Personnel Report), and personnel records and interview with personnel, the General Supervisor failed to perform semi-annual competency assessment for all aspects of duties for one (1) of one (1) testing personnel reviewed in 2026 for Histopathology testing. Findings: 1. Review of the laboratory's "Competency" policy revealed "Competency is assessed and documented prior to initiating testing, at six months during the first year of employment, at one year of employment and annually thereafter." 2. Review of the laboratory's CMS-209 form (Laboratory Personnel Report) revealed the laboratory had the following testing personnel: Testing Personnel 1 (also served as General Supervisor) Testing Personnel 2 3. In interview on June 15, 2026 at 12:11 p.m., the Histology Department Supervisor stated Testing Personnel 2 was hired in October 2025 and a semi-annual competency was performed. 4. Review of the personnel records for Testing Personnel 2 revealed a competency assessment dated June 15, 2026 and the assessment period documented was "11-25 to 5-26," but the laboratory failed to provide documentation to support the performance of each of the following "Six Required Methods" listed on the laboratory's competency form: *" Direct Observation of Routine Patient Test Performance" *"Monitoring the Recording and Reporting of Test Results" *"Review of Intermediate Test Results, Quality Control Records, Proficiency Testing Results, and Preventive Maintenance Records" *"Direct Observation of Performance of Instrument Maintenance and Function Checks" *Assessment of Test Performance Through Testing Previously Analyzed Specimens, Internal Blind Samples, or External Proficiency Testing Samples" *Assessment of Problem-Solving Skills"