Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	23D0871372	06/11/2026
Name of Provider or Supplier	**Street Address, City, State**	
Legacy Dermatology Group	1392 S Cass Lake Road, Waterford, MI	

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
D5209	PERSONNEL COMPETENCY ASSESSMENT POLICIES CFR(s): 493.1235 As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency. This STANDARD is not met as evidenced by: . Based on record review and interview with the Histology Technician (HT), the laboratory failed to ensure that initial and six-month competency assessments were performed for 1 (TP2) of 3 testing personnel reviewed. Findings include: 1. A review of the CMS-209 Form revealed that TP2 was listed as testing personnel performing high complexity testing. 2. A review of personnel competency assessment documentation revealed that TP2 began performing testing on October 20, 2025. Initial competency assessment and six-month competency assessment documentation were not available for review. 3. On 06/11/2026 at 12:15 p.m., the surveyor requested training and competency assessment documentation for TP2 and it was not provided. 4. A review of the laboratory's policy Legacy Dermatology Group, in the section titled "Training and Competency," paragraph #1, revealed that "All new laboratory personnel shall be trained on this SOP prior to performing independent slide labeling, with training documented in the personnel record." The policy further states in paragraph #2 that "Trained personnel shall sign a training attestation, that will also be signed by the laboratory director." 5. During an interview on 06/11/2026 at 12:15 pm, the HT confirmed initial training and competency assessment documentation had not been completed for TP2.
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: . Based on record review and interview with the Histology Technician (HT), the laboratory failed to verify the accuracy of its testing at least twice annually for 1 (2025) of 2 years reviewed. Findings include: 1. A review of the laboratory's records revealed the laboratory did not have documentation to demonstrate twice annual verification of accuracy for January 2025 through December 2025. 2. A review of the laboratory's policy titled "Proficiency Testing" in paragraph #1 revealed "The laboratory director will ensure that results of Mohs slides are verified since no proficiency testing program is available for Mohs surgery." Additionally, in paragraph #2, it reveals that "...Slides from at least 2 Mohs cases are given to the dermatopathologist at 'referral lab' A for review twice a year." 3. An interview on 06 /11/2026 at 1:15 pm with the HT confirmed twice annual verification of accuracy was not performed for 2025.