Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 31D0695812	(X3) Date Survey Completed 04/24/2018
Name of Provider or Supplier Dermatology Associates Of South Jersey	**Street Address, City, State** 112 White Horse Pike, Haddon Heights, NJ	

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
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 surveyor review of the Biannual Assessment (BA) records and interview with the Office Manager (OM), the laboratory failed to perform BA twice a year for Histopathology tests in the calendar year 2016 and 2017. The findings include: 1. A review of BA records revealed in 2016 Testing Personnel (TP) #2 listed on CMS form 209 performed BA once and in 2017 three of three TP performed BA once. 2. This was cited on the previous survey performed on 2/25/16 and the Plan of Correction stated a BA would be performed. 3. The OM confirmed on 4/24/18 at 12:45 am that BA was not performed twice a year.
D5601	HISTOPATHOLOGY CFR(s): 493.1273(a)(f) (a) As specified in 493.1256(e)(3), fluorescent and immunohistochemical stains must be checked for positive and negative reactivity each time of use. For all other differential or special stains, a control slide of known reactivity must be stained with each patient slide or group of patient slides. Reactions of the control slide with each special stain must be documented. (f) The laboratory must document all control procedures performed, as specified in this section. This STANDARD is not met as evidenced by: Based on surveyor review of the patient test reports, lack of Quality Control (QC) records and interview with the Office Manager (OM), the laboratory failed to

	document the reaction of immunohistochemical and special stains used in Histology Testing from 2/25/16 to the date of the survey. The finding includes: 1. Failure to document the reaction of a QC slide was cited on the previous survey performed on 2 /25/18 and the Plan of Correction stated: "Reactions of the control slide with each stain will be documented on the patients report and chart" beginning 2/25/16. 2. The OM confirmed on 4/25/18 at 1:30 PM that QC reactions were not documented.
D6093	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) The laboratory director must ensure that the quality control programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur. This STANDARD is not met as evidenced by: Based on surveyors review of the Procedure Manual and interview with the Office Manager (OM), the Laboratory Director failed to establish a Quality Control (QC) program for Histopathology tests from 2/25/16 to the date of survey. The OM confirmed on 4/24/18 at 1:00 pm that a QC program was not established.