Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	39D0696343	12/21/2020
Name of Provider or Supplier	**Street Address, City, State**	
Jefferson Dermatology Associates	33 S 9th Street, Suite 740, Philadelphia, PA	

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 review of the competency records and interview with the testing personnel (TP) #3 and the laboratory director (LD), the laboratory failed to establish written policies and procedures to assess the competency for 1 of 2 Clinical Consultants (CC) and 1 of 2 TP who analyzed Mohs microscopic examinations in 2018, 2019 and 2020. Findings Include: 1. On the day of survey, 12/21/2020, the laboratory could not provide a written procedure to assess the competency of 1 of 2 CC (CC#2) for their consultant responsibilities in 2018, 2019 and 2020. 2. The laboratory could not provide competency assessment records for CC#2, for their consultant responsibilities in 2018, 2019 and 2020. 3. The laboratory could not provide competency assessment records for TP#2, who analyzed Mohs microscopic examinations in 2018, 2019 and 2020. 4. The LD and TP#3 confirmed the findings above on 12/21/2020 around 9:10 am.
D6094	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) The laboratory director must ensure that the quality assessment 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 review of the laboratory records and interview of the Testing Personnel (TP) #3 and the laboratory director (LD), the LD failed to maintain the laboratory's Quality Assessment (QA) programs in 2018, 2019 and 2020. Findings Include: 1. The Lab Policy and Procedure Manual, Quality Assessment Plan states, "The mohs staff and director will discuss and evaluate the plan and make changes where its needed at the mohs meeting biannually". 2. On the day of survey, 12/21/2020, the laboratory could not provide QA meeting minutes performed biannual in 2018, 2019 and 2020. 3. The LD and TP#3 confirmed the findings above on 12/21/2020 at 9:20 am.