Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	39D1029392	08/30/2022
Name of Provider or Supplier	**Street Address, City, State**	
Schweiger Dermatology Group	822 Pine Street Suite 2a, 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 laboratory procedure manuals and interview with the Office Manager, the laboratory failed to establish a competency assessment procedure to assess 1 of 2 Clinical Consultants (CC) for their supervisory responsibilities from 07/29/2020 to the day of survey. Findings Include: 1. On the day of survey, 08/30/2022 at 10:30 am, the laboratory could not provide a competency assessment procedure to assess the competency for 1 of 2 CC (CMS 209 Personnel #2) from 7/29/2020 to 08/30/2022. 2. The Office Manager could not provide competency assessment documentation for 1 of 2 CC from 07/29/2020 to 08/30/2022. 3. The Office Manager confirmed the findings above on 08/30/2022 around 11:00 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 Quality Assurance policy, review of Monthly Patient Quality Assurance Checklists and interview with the Office Manager, the laboratory director (LD) failed to ensure quality assessment (QA) programs were followed to assure the

	quality of laboratory services provided from August 2020 to May 2022. Findings Include: 1. The quality assurance procedure states, "The lab director will also review and sign off the checklist monthly." 2. On the day of survey, 08/30/2022 at 10:04 am, review of the Monthly Patient Quality Assurance Checklist revealed that the LD did not review and sign off the monthly QA checklists from August 2020 to May 2022. 3. The Office Manager confirmed the findings above on 08/30/2022 around 11:00 am.
D6128	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(9) The technical supervisor is responsible for evaluating and documenting the performance of individuals responsible for high complexity testing at least annually after the first year, unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be reevaluated to include the use of the new test methodology or instrumentation. This STANDARD is not met as evidenced by: Based on review of the laboratory competency assessment records and interview with the Office Manager, the Technical Supervisor (TS) failed to evaluate the annual competency assessment for 1 of 2 Testing Personnel (TP) who performed MOHS Micrographic surgery slides examined from 07/29/2020 to the day of survey. Findings include: 1. On the day of survey 08/30/2022 at 10:07 am, the Office Manager could not provide competency assessment records for 1 of 2 TP (CMS 209 personnel #2) who performed MOHS Micrographic surgery slide examinations from 07/29/2020 to the day of survey. 2. The laboratory performed 375 MOHS Micrographic surgery slide examinations in 2021 (CMS 116 annual volume). 3. The Office Manager confirmed the findings above on 08/30/2022 around 11:00 am.