Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	42D2075023	04/23/2026
Name of Provider or Supplier	**Street Address, City, State**	
Liberty Doctors, Llc, Dba Tiffany Pediatrics	215 Town Creek Road, Aiken, SC	

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	An onsite unannounced recertification survey was conducted at Liberty Doctors DBA Tiffany Pediatrics on April 23, 2026, by the South Carolina Department of Public Health (SC DPH), Bureau of Nursing Homes and Medical Services. The facility was found to be out of compliance with the Medicare Conditions 42 CFR Part 493. CLIA laboratory requirements. The following CONDITION and STANDARD LEVEL DEFICINCIES were found to be out of compliance: D2000-42 C.F.R. 493.801 Condition: Enrollment and testing of samples.
D2000	ENROLLMENT AND TESTING OF SAMPLES CFR(s): 493.801 Each laboratory must enroll in a proficiency testing (PT) program that meets the criteria in subpart I of this part and is approved by HHS. The laboratory must enroll in an approved program or programs for each of the specialties and subspecialties for which it seeks certification. The laboratory must test the samples in the same manner as patients' specimens. For laboratories subject to 42 CFR part 493 published on March 14, 1990 (55 FR 9538) prior to September 1, 1992, the rules of this subpart are effective on September 1, 1992. For all other laboratories, the rules of this subpart are effective January 1, 1994. This CONDITION is not met as evidenced by: Based on record review, lack of documentation, and staff interview, the laboratory failed to enroll in a proficiency testing (PT) program for one or more tests that it performs for 4 out of 4 years reviewed (2022, 2023, 2024, and 2025). Findings included: 1. A review of Certification and Survey Provider Enhanced Reports (CASPER) 0096D reveals the laboratory performs specialty/subspeciality of microbiology analyte bacteriology. 2. A review of American Proficiency Institute (API) PT records reveals the laboratory failed to enroll in a PT program for 4 out of 4

	years reviewed (2022, 2023, 2024, and 2025). 3.In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.
D2007	TESTING OF PROFICIENCY TESTING SAMPLES CFR(s): 493.801(b)(1) (b)(1) The samples must be examined or tested with the laboratory's regular patient workload by personnel who routinely perform the testing in the laboratory, using the laboratory's routine methods. This STANDARD is not met as evidenced by: Based on record review, lack of documentation, and staff interview, the laboratory failed to ensure that PT samples were rotated among all testing personnel (TP) who routinely performed hematology testing for 4 out of 4 years reviewed (2022, 2023,2024, and 2025). Findings included: 1. A review of training records, PT raw data sheets, and CMS 209 personnel report form reveals the laboratory has 9 TP performing non-waived testing in the specialty and subspecialty of hematology on the day of the survey. 2. A review of records reveals the laboratory lack documentation of PT sample being examined or tested by personnel who routinely perform the testing in the laboratory, using the laboratory's routine methods. 3. In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.
D2014	TESTING OF PROFICIENCY TESTING SAMPLES (b)(6) The laboratory must document the handling, preparation, processing, examination, and each step in the testing and reporting of results for all proficiency testing samples. The laboratory must maintain a copy of all records, including a copy of the proficiency testing program report forms used by the laboratory to record proficiency testing results including the attestation statement provided by the PT program, signed by the analyst and the laboratory director, documenting that proficiency testing samples were tested in the same manner as patient specimens, for a minimum of two years from the date of the proficiency testing event. This STANDARD is not met as evidenced by: Based on record review, lack of documentation, and staff interview, the laboratory failed to ensure that the analyst performing the PT tests and the laboratory director (LD) sign the statement attesting that the PT samples were tested in the same manner as patient specimens for 4 out of 4 years reviewed (2022, 2023, 2024, and 2025). Findings included: 1. Review of CMS 209 laboratory personnel form reveals 9 TP. 2. Review of American Proficiency Institute (API) PT records reveal attestation pages were not signed on the day of inspection for 4 out of 4 years (2022, 2023, 2024, and 2025). 3. In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.
D6004	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(a)(b) The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform

	test procedures, and record and report test results promptly, accurate, and proficiently and for assuring compliance with the applicable regulations. (a) The laboratory director, if qualified, may perform the duties of the technical consultant, clinical consultant, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications of 493.1409, 493.1415, and 493.1421, respectively. (b) If the laboratory director reapportions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed. This STANDARD is not met as evidenced by: Based on record review, lack of documentation, and staff interviews the laboratory director failed to meet overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures and for assuring compliance with the applicable regulations as required 493.1407. Findings included: 1. A review of American Proficiency Institute (API) PT records reveals the laboratory director failed to sign attestation statements for 4 out of 4 years reviewed (2022, 2023, 2024, and 2025). The following Events were not signed on the day of inspection: a. 2022 Hematology/Coagulation, 1st Event b. 2022 Hematology /Coagulation, 2nd Event c. 2023 Hematology/Coagulation, 2nd Event d. 2023 Hematology/Coagulation, 3rd Event e. 2024 Hematology/Coagulation, 1st Event f. 2024 Hematology/Coagulation, 2nd Event g. 2025 Hematology/Coagulation, 3rd Event 2. Surveyor requested and the laboratory failed to provide competency records and quality assurance records providing effective direction over the operation of the laboratory. 3. In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.
D6005	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1407(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, lack of documentation, and staff interview, the laboratory director failed to document activities during on-site visits for at least once every 6 months, with at least 4 months between the minimum two on-site visits for 2 out 2 years reviewed (2025and 2026). Findings included: 1. A review of CMS 209 Laboratory Personnel Report (CLIA) reveals 1 laboratory director. 2. Surveyor requested and the laboratory failed to provide 2 documented visits for laboratory director during the 2 years reviewed. 3. In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.
D6046	TECHNICAL CONSULTANT RESPONSIBILITIES CFR(s): 493.1413(b)(8) (b)(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly,

	accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to-- This STANDARD is not met as evidenced by: Based on record review, lack of documentation, and staff interview, the laboratory failed to document competency of all testing personnel and assure that staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently for 4 out of 4 years reviewed (2022, 2023, 2024, and 2025). Findings included: 1. A review of CMS 209 laboratory personnel (CLIA) report reveals 9 TP. 2. A review of personnel records reveals training records for Sysmex XN-330/XN-350 (XNL) for 9 TP. No documentation of evaluator name or date the training was performed. 3. Surveyor requested but the laboratory failed to provide competency for all testing personnel performing moderately complex testing. No documentation was available on the day of inspection. 4. In an interview on April 23, 2026, at 2:50 pm in the conference room with office manager and owner the above findings were confirmed.