Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	42D2270268	04/17/2025
Name of Provider or Supplier	**Street Address, City, State**	
Waccamaw Dermatology	South Strand Medical Center, Suite 200, Myrtle Beach, 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 announced CLIA initial survey was conducted at the clinical laboratory of Waccamaw Dermatology of Myrtle Beach on April 17, 2025. The laboratory was found to be out of compliance with the Medicare Condition at 42 CFR Part 493, CLIA Requirements for Laboratories. Standard level deficiencies were identified for the initial survey during the survey.
D5291	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and, when indicated, correct problems identified in the general laboratory systems requirements specified at 493.1231 through 493.1236. This STANDARD is not met as evidenced by: Beased on records review, lack of documentation, and staff interview, the laboratory failed to have a written policy and procedure for biannual quality assessment and peer review of laboratory testing. Findings included: 1. Review of the laboratory procedure manual reveals a lack of a written policy and procedure for biannual quality assessment and peer review. 2. In an interview with the Office Manager on April 14, 2025 at 12:30pm in the laboratory office, the findings were confirmed.
D6093	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(5) (e)(5) Ensure that the quality control and 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 records review, lack of documentation, and staff interview, the laboratory director failed to ensure that there was a written policy and procedure for quality assessment programs. Findings included: 1. Review of the laboratory's procedure manual reveals a lack of a written policy and procedure for biannual quality assessments and peer review. 2. In an interview with the Office Manager on April 14, 2025 at 12:30pm in the laboratory office, the findings were confirmed.