Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	45D0689775	04/10/2025
Name of Provider or Supplier	**Street Address, City, State**	
Clear Lake Dermatology	13938 Hwy 3 Unit 100, Webster, TX	

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	A recertified survey was completed on 04/10/2025. Noted deficiencies and plans of correction were discussed with the laboratory representative(s) at the exit conference. The facility was found to be in compliance with applicable Conditions in the CLIA program, and recertification is recommended.
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 the review of the laboratory's CMS 209 Laboratory Personnel Report, the laboratory's records, personnel competency records, and confirmed in an interview, the laboratory failed to have documentation of competency assessment for 1 of 2 clinical consultants, 1 of 1 technical supervisor, and 1 of 2 general supervisor. The findings were: 1. Review of the laboratory's records reveal no policy available for personnel competency assessment. 2. Review of the laboratory's CMS 209 Laboratory Personnel Report, signed by the laboratory director on 04/10/2025, revealed the laboratory identified 2 clinical consultants, 1 technical supervisor and 2 general supervisors. 3. Review of the laboratory's personnel competency records revealed the laboratory failed to have documentation of competency assessment for 1 of 2 clinical consultants, 1 of 1 technical supervisor, and 1 of 2 general supervisor. Clinical consultant#2, technical supervisor#1, and general supervisor#2: Hired date: 11/24 /2014 4. In an interview on 04/10/2025 at 12:00 pm in an office, the laboratory director confirmed the above findings. Key: CMS=Center of Medicare and Medicaid Services CMS 209 form=Laboratory Personnel Report (CLIA)
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 the review of the laboratory's alternative proficiency testing records, MOHS log sheets from September to December in 2024, and confirmed in an interview, the laboratory failed to verify 1 of 2 twice annual accuracy check for MOHS procedure in 2024. The findings were: 1. Review of the laboratory's the laboratory's alternative proficiency testing records revealed the laboratory verified accuracy check in February 2024 (Expired in August 2024) and the next in April 2025. 2. Further review of the laboratory's the laboratory's alternative proficiency testing records revealed the laboratory failed to verify 1 of 2 twice annual accuracy check for MOHS procedure in 2024. 3. Review of the laboratory's MOHS log sheets from September to December in 2024 revealed the laboratory performed 93 MOHS cases. 4. In an interview on 04/10 /2025 at 11:55 am in an office, the laboratory director confirmed the above findings.