Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	49D2297032	01/20/2026
Name of Provider or Supplier	**Street Address, City, State**	
Complexions Dermatology Pc	117 Executive Drive, Danville, VA	

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 announced CLIA recertification survey was conducted at Complexions Dermatology, PC on January 20, 2026 by the Virginia Department of Health's Office of Licensure and Certification. Complexions Dermatology, PC was not in compliance with applicable Standards and Condition under 42 CFR part 493 CLIA Regulations. Specific deficiencies cited are as follows and include the Condition: D6076 - 42 CFR 493.1441 Condition: Laboratory Director.
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 review of procedures, proficiency testing (PT) records, lack of documentation, and interviews, the laboratory failed to perform mohs histopathology accuracy checks by peer review twice annually per laboratory policy during seventeen (17) of 17 months reviewed (timeframe: initial survey August 28, 2024 to recertification on January 20, 2026). Findings include: 1. Review of the laboratory's procedures revealed a quality assurance policy for PT. The policy stated "Two cases every six months are selected at random and are sent to another surgeon for review. The maps and slides are pulled, slides for each case will be individually peer evaluated with results marked on the map, tabulation will be made to the degree of concordance. The concordance ratio is expected to exceed 90% on annual basis." 2. Review of the laboratory's PT files for the 17 months of review (8/28/24-1/20/26) revealed no peer review had been documented. The inspector requested to review PT accuracy records for the review timeframe. No records were available. 3. The inspector inquired as to the reason peer review cases were not pulled twice annually as outlined in the quality assurance policy. The mohs staff members stated on 1/20/26 at 11 AM, "We had pulled two cases from October and December 2024 and two cases

	from April 2025 and plan to send out to another mohs surgeon for peer review. We have not sent them out yet." 4. An interview with the mohs laboratory staff members and laboratory director on 1/20/26 at 12:30 PM confirmed the above findings.
D6076	LABORATORY DIRECTOR CFR(s): 493.1441 The laboratory must have a director who meets the qualification requirements of 493. 1443 of this subpart and provides overall management and direction in accordance with 493.1445 of this subpart. This CONDITION is not met as evidenced by: Based on review of the Centers for Medicare and Medicaid Services CLIA Laboratory Application for Certification form, quality assessment (QA) policies, proficiency testing (PT) records, lack of documentation, and interviews, the laboratory director failed to identify PT QA failures as they occurred when twice annual peer review was not performed per policy in calendar year 2025. *Refer to D6093.
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 review of the Centers for Medicare and Medicaid Services CLIA Laboratory Application for Certification (CMS 116), quality assessment (QA) policy, proficiency testing (PT) peer review records, lack of documentation, and interviews, the laboratory director (LD) failed to identify PT quality assessment failure during seventeen (17) of 17 months reviewed (timeframe: August 28, 2024 to January 20, 2026). Findings include: 1. Review of the CMS 116 report revealed that the LD identified high complexity histopathology mohs slide reading was performed during the 17 month review timeframe of 8/28/24 - 1/20/26. 2. Review of the laboratory's procedures revealed a QA policy for PT. The policy stated "Two mohs cases every six months are selected at random and are sent to another surgeon for peer review." 3. The inspector requested peer reviewed PT documentation during the 17 months of 8 /28/24 - 1/20/26. The records were not provided. 4. The inspector inquired regarding documentation that the LD identified/recorded corrective action for the PT lapse in the timeframe outlined above. No corrective action documentation was available. 5. An interview with the mohs staff members and LD on 1/20/26 at 12:30 PM confirmed the above findings.