Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D1037447	07/03/2025
Name of Provider or Supplier	**Street Address, City, State**	
Advanced Desert Dermatology	9191 W Thunderbird Rd, Ste D-101, Peoria, AZ	

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
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 lack of accuracy verification documentation for Mohs and interview with the facility personnel, the laboratory failed to verify the accuracy of testing performed under the subspecialty of Histopathology at least twice annually during 2024. Findings include: 1. No documentation was presented for review to indicate the laboratory verified the accuracy of Mohs testing at least twice annually during 2024. 2. The facility personnel interviewed on 7/03/25 at 10:08 AM confirmed the laboratory failed to verify the accuracy of Mohs testing testing at least twice annually during 2024. 3. The laboratory's reported annual test volume is 516. **This is a repeat deficiency from the previous survey conducted on 6/28/24.
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: Based on review of established quality assessment (QA) policies on July 3, 2025 and interview with the facility personnel, the laboratory's QA process failed to monitor, assess and correct problems related to the verification of accuracy process for Mohs

	testing during 2024. Findings include: 1. The laboratory performs the microscopic interpretation of patient slides in conjunction with the Mohs procedure in the subspecialty of Histopathology, with a reported annual test volume of 516. 2. The laboratory failed to verify the accuracy of the microscopic interpretation of Mohs slides during 2024. See D5217 for findings. 3. The laboratory's established QA policy states, "The programs and methods used for proficiency testing and results of the testing will be evaluated by the Laboratory Director or an appropriate, designated staff member every 6 months." 4. No documentation was presented for review to indicate the laboratory followed the established QA policy indicated above to monitor, assess and correct problems identified with accuracy verification of Mohs testing during 2024. 5. The facility personnel interviewed on 7/03/25 at 10:16 AM acknowledged that the laboratory's QA processes at the time of the survey were not effective at monitoring, assessing and correcting problems identified in the general laboratory system.
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 lack of Quality Assessment (QA) documentation from 2024 and interview with the facility personnel, the laboratory director failed to ensure that QA programs are maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur. Findings include: 1. The laboratory performs testing in the subspecialty of Histopathology with a reported annual test volume of 516. 2. The laboratory failed to provide evidence of documented QA activities from 2024. (See D5291 for specific findings) 3. The laboratory director failed to ensure that the Plan of Correction provided by the laboratory for the deficiency (D5217) cited during the previous inspection conducted on 6/28/24 was implemented and monitored to ensure the deficient practice was corrected and did not recur. 4. The facility personnel interviewed on 7/03/2025 at 10:24 AM confirmed that the laboratory director failed to ensure QA activities were performed and documented during 2024, as indicated in the laboratory's Plan of Correction from the previous CLIA survey conducted on 6/28/24.