Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 03D1062136	(X3) Date Survey Completed 10/17/2025
Name of Provider or Supplier Arizona Dermatology-Apache Junction	**Street Address, City, State** 2430 W Apache Trail Ste 5, Apache Junction, 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
D5203	SPECIMEN IDENTIFICATION AND INTEGRITY CFR(s): 493.1232 The laboratory must establish and follow written policies and procedures that ensure positive identification and optimum integrity of a patient's specimen from the time of collection or receipt of the specimen through completion of testing and reporting of results. This STANDARD is not met as evidenced by: Based on review of Mohs test records and interview with the facility personnel, the laboratory failed to ensure positive identification for 1 out of 3 dermatopathology specimens from the time of collection through completion of testing and reporting of test results. Findings include: 1. The laboratory performs testing in conjunction with the Mohs procedure under the subspecialty of Histopathology, with a reported annual test volume of 50. It is the practice of the laboratory to assign a unique accession number to each Mohs specimen. The unique accession number is documented on the laboratory's Mohs log, Mohs map, patient's slides and final test report maintained in the patient's Electronic Medical Record (EMR). 2. The laboratory failed to ensure positive identification of a patient's specimen throughout the entire test process for 1 out of 3 Mohs cases reviewed during the survey (Case: AJ6031 performed on 10/11 /24). Direct observation of three of six patient slides, second page of the Mohs map and the laboratory's Mohs log listed the patient's last name as "Qualstrom." The patient's last name listed in the patient's EMR was "Quanstrom." 3. The facility personnel interviewed on 10/17/25 at 11:30 AM acknowledged that the last name for the patient referenced above was incorrectly recorded in the Mohs log, three of six patient slides and on the second page of the Mohs map, and acknowledged that the laboratory failed to ensure positive identification of a patient's specimen from the time of collection through completion of testing and reporting of results.