Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D1079908	03/03/2023
Name of Provider or Supplier	**Street Address, City, State**	
English Dermatology	20940 North Tatum Blvd Ste 200, Phoenix, 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 the patients Mohs maps, patient slides and final test reports for Mohs maintained in the patient's Electronic Medical Record (EMR), and interview with the facility personnel, the laboratory failed to follow policies and procedures that ensure positive identification of dermatopathology specimens from the time of collection through completion of testing and reporting of test results. Findings include: 1. The laboratory performs Mohs testing under the sub-specialty of histopathology, with an approximate annual test volume of 211. It is the practice of the laboratory to assign a unique accession number to each Mohs specimen. The unique accession number is included on the Mohs log recorded by laboratory personnel, Mohs map, patients' 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 for Mohs testing throughout the entire test process for patient J.M. for testing performed on 3/23/2021 as evidenced by: the patient slides and Mohs map were labeled with accession# 039-21, and the final test report maintained in the EMR indicated accession# 034-21. 3. The facility personnel interviewed on 3/03/2023 at 10:15am acknowledged that the laboratory failed to ensure positive identification of the patient's specimens from the time of collection through completion of testing and reporting of results, as evidenced by the specimen identification errors that occurred on 3/23/2021.