Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2018247	02/24/2026
Name of Provider or Supplier	**Street Address, City, State**	
Grand Canyon Dermatology	1150 North Country Club Dr, Ste 6, Mesa, 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 testing performed in the subspecialty of Histopathology and interview with the facility personnel on 2/24/26 at 11:10 AM, the laboratory failed to verify the accuracy of the microscopic interpretation of Mohs specimens at least twice annually during 2024 and 2025. Findings include: 1. No documentation was presented for review to indicate the laboratory verified the accuracy of the microscopic interpretation of Mohs specimens at least twice annually during 2024 and 2025. 2. The facility personnel interviewed on 2/24/26 at 11:10 AM confirmed the laboratory failed to verify the accuracy of Histopathology testing at least twice annually during 2024 and 2025. 3. The laboratory began testing on 8/29/24 and performs 1,800 tests annually under the subspecialty of Histopathology.
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 a lack of Quality Assessment (QA) records and interview with the facility

	personnel on 2/24/26 at 11:20 AM, the laboratory failed to establish policies and procedures for the accuracy verification process of Mohs specimens, and the laboratory's QA processes failed to monitor, identify and correct errors related to the accuracy verification process for Mohs specimens. Findings include: 1. The laboratory began patient testing on 8/29/24 under the subspecialty of Histopathology with a reported annual test volume of 1,800. The laboratory performs the microscopic interpretation of Mohs specimens. 2. No documentation was presented for review to indicate the laboratory established policies and procedures related to the accuracy verification process for Mohs testing, including but not limited to, the frequency of the review, number of cases reviewed, individual or laboratory performing the review and a remedial action plan in the event of a noted discrepancy. 3. The laboratory's QA processes failed to monitor, identify and correct errors found with the failure to verify the accuracy of Mohs testing at least twice annually in 2024 and 2025. (See D5217 for findings) 4. The facilty personnel interviewed on 2/24/26 at 11:20 AM confirmed the laboratory failed to provide evidence of an established policy and procedure specific to the verification of accuracy process for the microscopic interpretation of Mohs specimens, and acknowledged that the laboratory's QA processes were not effective at monitoring, identifying and correcting errors found with accuracy verification activities.