Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2045374	10/09/2025
Name of Provider or Supplier	**Street Address, City, State**	
Dyson Dermatology, Pllc	2222 N Craycroft Rd, Ste 100, Tucson, 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
D5801	TEST REPORT CFR(s): 493.1291(a) (a) The laboratory must have an adequate manual or electronic system(s) in place to ensure test results and other patient-specific data are accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to final report destination, in a timely manner. This includes the following: (a)(1) Results reported from calculated data. (a)(2) Results and patient-specific data electronically reported to network or interfaced systems. (a)(3) Manually transcribed or electronically transmitted results and patient-specific information reported directly or upon receipt from outside referral laboratories, satellite or point-of-care testing locations. This STANDARD is not met as evidenced by: Based on review of final test result information for Mohs maintained in the Electronic Health Record (EHR), review of established policies and procedures and interview with the facility personnel on 10/09/25 at 11:27 AM, the laboratory failed to accurately report Mohs test results in the patient's EHR for one out of two patient records reviewed during the survey. Findings include: 1. Specimen information and the final test result for Mohs is manually transcribed by laboratory personnel into the patient's EHR. 2. The laboratory's established policy titled, "Documentation for Mohs Surgery in the Electronic Health Record EMA", states, "All documentation is double-checked by the lab technician, who ensures the Mohs Flow Chart is uploaded to the patient's chart and that all information in the visit note is accurate and precise prior to note finalization." 3. One out of two Mohs cases reviewed (# M25-009) failed to include the correct accession number in the patient's EHR. The EHR record listed the accession number as M24-009, and the Mohs log, patient slides and Mohs map listed the the accession number as M25-009. 4. The laboratory failed to follow their established policy indicated above to ensure the visit note for Mohs case# M25-009 was accurate and precise prior to note finalization. 5. The facility personnel interviewed on 10/09/25 at 11:27 AM confirmed the Mohs accession number listed in

	the EHR for case# M25-009 was incorrect and confirmed that the laboratory failed to follow their established policy to ensure the accuracy of manually transcribed test information. 6. The laboratory performs testing in the subspecialty of Histopathology with a reported annual test volume of 4,342.
D6102	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(12) (e)(12) Ensure that prior to testing patients specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results; This STANDARD is not met as evidenced by: Based on lack of initial training documentation for 2 out of 2 testing personnel (TP-2 and TP-3) and interview with facility personnel on 10/09/25 at 10:55 AM, the laboratory director failed to ensure that all testing personnel receive the appropriate training and demonstrate that they can perform all testing operations reliably and accurately prior to testing patients' specimens. Findings include: 1. No initial training documentation was presented for review for 2 out of 2 testing personnel (TP-2 and TP-3) who perform the gross examination of dermatopathology specimens in the specialty of Pathology. 2. The facility personnel interviewed on 10/09/25 at 10:55 AM confirmed the laboratory failed to provide documentation of initial training for the two testing personnel indicated above. 3. The laboratory began performing the gross examination of dermatopathology specimens on 3/03/25 and reports an annual test volume of 4,296.
D6103	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(13) (e)(13) Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills; This STANDARD is not met as evidenced by: Based on personnel record review and review of laboratory policies and procedures on 10/09/25 at 11:00 AM, the laboratory director failed to establish policies and procedures for monitoring and assessing the competency of 2 out of 2 testing personnel who conduct testing in the subspecialty of histopathology. Findings include: 1. The laboratory employs two testing personnel who perform the gross examination of dermatopathology specimens. 2. The laboratory director failed to establish policies and procedures to monitor individuals who perform the gross examination of dermatopathology specimens, to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills. 3. The facility personnel interviewed on 10/09/25 at 11:00 AM acknowledged the laboratory director failed to establish policies and procedures to assess the competency of testing personnel who

	perform the gross examination of dermatopathology specimens. 4. The laboratory performs 4,296 tests annually in the specialty of Histopathology.
D6127	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(9) (b)(9) Evaluating and documenting the performance of individuals responsible for high complexity testing at least semiannually during the first year the individual tests patient specimens. This STANDARD is not met as evidenced by: Based on lack of documentation of semiannual competency evaluations for 2 out of 2 testing personnel and interview with facility personnel on 10/09/25 at 10:26 AM, the technical supervisor failed to evaluate and document the performance of individuals responsible for the gross examination of dermatopathology specimens at least semiannually during the first year the individuals tested patient specimens. Findings include: 1. No evidence of a semiannual competency evaluation was presented for review for two out of two testing personnel (TP-2 and TP-3) who perform the gross examination of dermatopathology specimens. 2. The facility personnel interviewed on 10/09/25 at 10:26 AM confirmed the technical supervisor failed to perform and document semiannual competency evaluations for the 2 testing personnel indicated above. 3. The laboratory began performing the gross examination of dermatopathology specimens on 3/03/25 with a reported annual test volume of 4,296.