Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2058341	06/22/2026
Name of Provider or Supplier	**Street Address, City, State**	
Prescott Healthcare Solutions, Llc Dba	3151 N Windsong Dr, Prescott Valley, 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
D5293	GENERAL LABORATORY SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1239(b)(c) (b) The general laboratory systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of general laboratory systems quality assessment reviews with appropriate staff. (c) The laboratory must document all general laboratory systems quality assessment activities. This STANDARD is not met as evidenced by: Based on review of Proficiency Testing (PT) results, review of PT corrective action records and interview with the technical consultant (TC-1) on June 15, 2026 at 11:10 AM, the laboratory's corrective action documentation failed to include the findings and the corrective action taken to resolve problems associated with unsatisfactory PT scores for Vitamin D during the 1st PT event of 2026. Findings include: 1. The laboratory performs patient testing in the specialty of chemistry, with a reported annual test volume of 1,295,113. 2. PT records reviewed during the survey from the 1st event of 2026 indicated the laboratory received a score of 80% for Vitamin D (PT sample# IAS-02 received a score of 0% resulting in a overall analyte score of 80%). 3. It is the practice of the laboratory to investigate all PT scores that result in a score of less than 100%. The laboratory utilizes a 'Corrective Action Checklist" provided by the PT organization, American Proficiency Institute (API), to document corrective action. The form includes an area to document the "findings", "corrective action" and contains the question, "Could patient results have been affected? If so, explain course of action". 4. The Corrective Action Checklist presented for review for the 1st event of 2026 for Vitamin D failed to include documentation regarding the findings, the corrective action taken by the laboratory and patient outcome. 5. The TC-1 interviewed on 6/15/26 at 11:10 AM confirmed the Vitamin D corrective action

	documentation referenced above failed to include information regarding the findings, the corrective action taken by the laboratory and whether or not the unsatisfactory PT score affected patient results.
D5813	TEST REPORT CFR(s): 493.1291(g) (g) The laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values. This STANDARD is not met as evidenced by: Based on review of the laboratory's critical value policy, review of patient test reports containing critical values and interview with the technical consultant (TC-1) on June 15, 2026 at 12:38 PM, the laboratory failed to immediately alert the individual or entity requesting the test of a critical Glucose test result for 1 out of 2 patient test reports reviewed from 2026. Findings include: 1. The laboratory performs testing in the specialties of chemistry and hematology, with a reported annual test volume of 1,654,721. 2. The laboratory's established critical value policy states, "The laboratory is required to document the appropriate clinical individual receiving and acknowledging the notice of critical value test results. When results are communicated verbally, laboratory personnel are also required to ask for a verification "read back" of the critical value test results to ensure clear communication". 3. One out of two test reports showing critical test values (Patient #4, Glucose result of 522 mg/dL) failed to include documentation to indicate the laboratory immediately notified the individual or entity requesting the test of the critical test result. 4. TC-1 interviewed on 6/15/26 at 12:38 PM confirmed the laboratory failed to provide evidence showing the individual or entity requesting the test was immediately notified of the critical Glucose test result referenced above.