Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2070894	07/12/2023
Name of Provider or Supplier	**Street Address, City, State**	
Skin And Cancer Center Of Arizona	725 S Dobson Rd, Room 201, Chandler, 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 2022, 2023 "Monthly Quality Assurance Meeting Checklists" and "Lab Error Logs" and interview with testing personnel (TP) #4, the laboratory failed to review the effectiveness of corrective actions taken to resolve problems and prevent recurrence of the problems. Findings: 1. Review of 2022 and 2023 "Monthly Quality Assurance Meeting Checklists" showed for 17 of 18 months the laboratory documented a "No" for specimens logged in correctly. 2. Review of the "Lab Error Logs" showed 62 documented entries from June 3, 2021 to June 26, 2023. 3. Interview with TP #3 and #4 on July 12, 2023 at 11:00 AM confirmed the laboratory failed to review the effectiveness of corrective actions taken to resolve problems to prevent recurrence. 4. The laboratory results approximately 25,000 histopathology tests annually.
D6103	LABORATORY DIRECTOR RESPONSIBILITIES CFR(s): 493.1445(e)(13) The laboratory director must 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 review of competency documentation, procedure manual, and interview with testing personnel (TP) #4, the laboratory director (LD) failed to perform three of three competencies for 2022. Findings: 1. Review of competency documentation showed no competency evaluations for 2022 for three of three testing personnel for high complexity testing 2. Review of the procedure manual showed, "Yearly Training Verification and Competency for all laboratgory employees are kept in this section." 3. Interview with TP #4 on July 12, 2023 at 11:00 AM confirmed, the LD failed to evaluate the competency of all testing personnel for 2022. 4. The laboratory results approximately 25,000 histopathology results annually.