Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2111120	06/05/2025
Name of Provider or Supplier	**Street Address, City, State**	
Center For Dermatology, Pllc	6316 W Union Hills Dr Ste 200, Glendale, 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
D5891	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(a) (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 postanalytic systems specified in 493.1291. This STANDARD is not met as evidenced by: **Based on lack of Quality Assessment (QA) documentation from 2024, review of established QA policies and interview with the facility personnel, the laboratory failed to follow established policies and procedures for an ongoing mechanism to monitor, assess and, when indicated, correct problems identified in the postanalytic systems. Findings include: 1. Patient-specific data and the final test result information for Mohs and Frozen Biopsy testing is manually transcribed by laboratory personnel into the patient's Electronic Health Record (EHR). 2. The laboratory's Quality Assessment policy states, "Our laboratory uses a QA Program which includes review/case reviews to ensure the processes were performed and documented correctly and that there were no significant errors in the processes, documentation, or diagnosis. The QA form will be attached with the Biannual Peer Review. Biannually, 5 cases will be randomly selected. Biannually up to 2 frozen sections will be pulled for review if performed. If issues noted would impact patient care, then remedial actions will be taken and documented immediately." 3. No documentation was presented for review to indicate the laboratory followed the policy referenced above to perform a biannual audit of 5 Mohs cases and 2 frozen section cases during 2024. 4. The facility personnel interviewed on 6/05/25 at 10:55 AM confirmed the laboratory failed to perform and document the QA review indicated above during 2024. 5. The laboratory performs approximately 780 tests annually under the subspecialty of Histopathology. **This is a repeat deficiency from the previous inspection conducted on 12/14/2023
D6093	LABORATORY DIRECTOR RESPONSIBILITIES

	CFR(s): 493.1445(e)(5) (e)(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur; This STANDARD is not met as evidenced by: Based on lack of Quality Assessment (QA) documentation from 2024 and interview with the facility personnel, the laboratory director failed to ensure that QA programs are maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur. Findings include: 1. The laboratory performs testing in the subspecialty of Histopathology with a reported annual test volume of 780. 2. The laboratory failed to provide evidence of documented QA activities from 2024. (See D5891 for specific findings) 3. The laboratory director failed to ensure that the Plan of Correction provided by the laboratory for the deficiency (D5891) cited during the previous inspection conducted on 12/14/23 was implemented and monitored to ensure the deficient practice was corrected and did not recur. 4. The facility personnel interviewed on 6/05/2025 at 10:55 AM confirmed that the laboratory director failed to ensure that QA activities were performed and documented during 2024 as indicated in the laboratory's previous Plan of Correction from the CLIA survey conducted on 12/14 /23.