Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03D2326501	06/02/2026
Name of Provider or Supplier	**Street Address, City, State**	
Tucson Dermatology-Oro Valley	1521 E Tangerine Rd Ste 205, Oro 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
D5203	SPECIMEN IDENTIFICATION AND INTEGRITY CFR(s): 493.1232 The laboratory must establish and follow written policies and procedures that ensure positive identification and optimum integrity of a patient's specimen from the time of collection or receipt of the specimen through completion of testing and reporting of results. This STANDARD is not met as evidenced by: Based on review of Mohs test records and interview with the facility personnel on 6/02/26 at 10:23 AM, the laboratory failed to ensure positive identification for 1 out of 4 patient's specimens for Mohs from the time of collection through reporting of test results in the Electronic Medical Record (EMR). Findings include: 1. The laboratory performs the microscopic interpretation of Mohs specimens under the subspecialty of Histopathology, with an approximate annual test volume of 300. The laboratory began patient testing on 8/22/25. 2. The laboratory utilizes a Mohs log each day of patient testing to record the date of testing, patient name, Mohs accession number, Mohs site and number of stages. This information is also recorded on the patient's Mohs map and is recorded in the patient's EMR. 3. The laboratory failed to ensure positive identification for 1 out of 4 Mohs specimens (Patient #1) from time of collection through reporting of test results in the EMR as evidenced below: - The Mohs log listed the site as 'mid-occipital scalp' and number of stages as '2'. - The EMR operative note, patient's slides and Mohs map listed the site as 'right distal calf' and the number of stages as '1'. 4. The facility personnel interviewed on 6/02/26 at 10:23 AM confirmed that the Mohs site and number of stages listed on the Mohs map, patient's slides and entered into the EMR for Patient #1 was correct, and the information listed on the Mohs log was incorrect.
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 review of laboratory policy, review of accuracy verification documentation for the microscopic interpretation of Mohs specimens and interview with the facility personnel on 6/02/26 at 11:28 AM, the laboratory failed to follow their established policy to verify the accuracy of Mohs testing performed under the subspecialty of Histopathology at least semiannually during 2026. Findings include: 1. The laboratory performs the microscopic interpretation of Mohs specimens in the subspecialty of histopathology with a reported annual test volume of 300. The laboratory began patient testing on 8/22/25. 2. The laboratory's established policy titled, "Proficiency Testing - Mohs Micrographic Surgery Skin Specimens" states, "Semi-annually, the tech or Risk Manager will send two cases containing the original slides, label it with only the surgical case number, and send it out for a microscopic examination by a Board Certified Dermatopathologist....Results of each Proficiency Test will be entered in a log and kept in the laboratory management manual, as part of its permanent records." 3. Review of the accuracy verification records for Mohs cases revealed the laboratory sent 4 cases for review in May 2026 (signed off by the reviewing physician on 5/22/26). 4. The laboratory failed to follow their established policy indicated above as evidenced by the failure to send off two Mohs cases semi-annually after patient testing began in August 2025. Two Mohs cases should have been sent out for review in February 2026 per laboratory policy. 5. The facility personnel interviewed on 6/02 /26 at 11:28 AM acknowledged the laboratory failed to follow their established policy to verify the accuracy of histopathology testing at least semiannually after patient testing began in August 2025.
D5787	TEST RECORDS CFR(s): 493.1283(a) (a) The laboratory must maintain an information or record system that includes the following: (a)(1) The positive identification of the specimen. (a)(2) The date and time of specimen receipt into the laboratory. (a)(3) The condition and disposition of specimens that do not meet the laboratory's criteria for specimen acceptability. (a)(4) The records and dates of all specimen testing, including the identity of the personnel who performed the test(s). This STANDARD is not met as evidenced by: Based on review of patients' slides for the microscopic interpretation of Mohs specimens and interview with the facility personnel on 6/02/26 at 10:44 AM, the laboratory failed to indicate the correct testing date on 1 out of 4 patient's slides. Findings include: 1. The laboratory performs the microscopic interpretation of Mohs specimens under the subspecialty of histopathology, with an approximate annual test volume of 300. The laboratory began patient testing on 8/22/25. 2. The laboratory failed to label 1 out of 4 patient's Mohs slides with the correct testing date. The Mohs log, Mohs map and test information entered into the electronic medical record (EMR) for Patient # 2 indicated the correct testing date as 5/11/26. The patient's slides were labeled with the testing date of 5/08/26. 3. The facility personnel interviewed on 6/02 /26 at 10:44 AM confirmed that the Mohs slides for the patient indicated above were labeled with the incorrect testing date.

D5805	TEST REPORT CFR(s): 493.1291(c) (c) The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability. This STANDARD is not met as evidenced by: Based on review of pathology test reports for the microscopic interpretation of frozen biopsy specimens and interview with the facility personnel on 6/02/26 at 10:55 AM, the laboratory failed to include the gross description and the microscopic description on 1 out of 1 frozen biopsy test reports reviewed during the survey. Findings include: 1. The laboratory performs the diagnostic interpretation of dermatopathology specimens in the subspecialty of histopathology, with a reported annual test volume of 300. The laboratory began patient testing on 8/22/25. 2. One out of one frozen biopsy test reports (Patient #3) failed to include the gross description and the microscopic description. The gross description (including weighing, measuring, describing color, specific orientation for diagnostic interpretation, and other characteristics of the tissue) and the microscopic description must be included on the pathology test report. 3. The facility personnel interviewed on 6/02/26 at 10:55 AM acknowledged that the gross description and the microscopic description were missing from the frozen biopsy test report referenced above. 4. The laboratory performed 3 frozen biopsies during the time frame of 8/22/25 through 6/02/26.