

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  10D1032489	<b>(X3) Date Survey Completed</b>  09/15/2022
<b>Name of Provider or Supplier</b>  Paul Herschel Bowman Md Pa D/B/A	<b>Street Address, City, State</b>  5379 Primrose Lake Cir, Tampa, FL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>
<b>D0000</b>	An announced CLIA recertification survey was conducted at Paul Herschel Bowman MD Pa d/b/a Bowman Institute for Dermatologic Surgery on 09/15/22. The laboratory is not in compliance with 42 CFR Part 493, Requirements for Laboratories. The following is a description of the standard level deficiencies:
<b>D5217</b>	<p><b>EVALUATION OF PROFICIENCY TESTING PERFORMANCE</b> CFR(s): 493.1236(c)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the laboratory failed to send Mohs histopathology patient slides for peer review twice annually for two of two years reviewed (2020 &amp; 2021). Findings included: Record review of documented peer review showed that patient slides were not sent out for accuracy verification twice annually in 2020 and 2021. Review of the laboratory QA (Quality Assurance) protocol revealed: "To follow the proficiency of slide interpretation, slides of three randomly selected Mohs cases will be sent to an outside consultant for evaluation biannually." Interview with Testing Person A, on 9/15/22 at 9:30 a.m. confirmed that slides had not been sent out since 2019 and when the error was discovered, she sent out slides from 2020 and 2021 for peer review in 2022.</p>
<b>D5609</b>	<p><b>HISTOPATHOLOGY</b> CFR(s): 493.1273(e)(f)</p> <p>(e) The laboratory must use acceptable terminology of a recognized system of disease nomenclature in reporting results. (f) The laboratory must document all control procedures performed, as specified in this section.</p>

This STANDARD is not met as evidenced by:

Based on record review and staff interview, the laboratory failed to maintain complete Histopathology quality control documentation for 21 of 21 months reviewed (January 2021 until September 2022). Findings included: Record review of quality control documentation showed there was no record of lot numbers and expiration dates for the Hematoxylin and Eosin (H&E) stains that were used on patient histopathology slides during processing. Interview with Testing Person A, on 9/15/22 at 10:15 a.m., confirmed that she does not keep any quality control logs that record the lot number and expiration dates for the H&E stains.