

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  10D2038307	<b>(X3) Date Survey Completed</b>  08/20/2019
<b>Name of Provider or Supplier</b>  Partners In Medicine And Surgery Pa D/B/A	<b>Street Address, City, State</b>  2441 Oak Myrtle Ln Ste 101, Wesley Chapel, 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 Partners in Surgery and Medicine PA d/b/a 360 Dermatology on 08/20/19. 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 interview with the Director of Operations, the laboratory failed to verify the accuracy of Histopathology testing which included hematoxylin and eosin at least twice annually for 2 out of 2 years (2018-2019) reviewed. Findings Included: Policy and procedures revealed that Quality Assurance Program for Histopathology peer review states "it is suggested to submit 3 cases every 6 months to outside pathologist". Record review of peer reviews revealed that 1 peer review was conducted on 07/19 which included patients from 2018 and 2019. No other peer reviews were performed. Interview on 08/20/19 at 11:00 AM with the Director of Operations revealed she did not know she could not cover two years in one peer review.</p>
<b>D5481</b>	<p><b>CONTROL PROCEDURES</b> CFR(s): 493.1256(f)(g)</p> <p>(f) Results of control materials must meet the laboratory's and, as applicable, the manufacturer's test system criteria for acceptability before reporting patient test results. (g) The laboratory must document all control procedures performed.</p>

This STANDARD is not met as evidenced by:  
Based on record review and interview with the Laboratory Director, the laboratory failed to document the quality of Histopathology hematoxylin and eosin (H&E) control slides for 2 out of 2 years (2018-2019) Findings Included: Review of the policy "Quality Assurance for Routine Stains" revealed the lab director would determine acceptability of the stain each day and the quality control (QC) would be documented on the stain QC chart. Record review of the laboratory logs revealed the logs did not include the stain QC chart for 2 out of 2 years (2018-2019). On 08/20/19 at 12:00 PM, the Laboratory Director stated that the missing quality control documentation was due to an oversight.