

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  04D0980519	<b>(X3) Date Survey Completed</b>  05/10/2018
<b>Name of Provider or Supplier</b>  Amity Community Health Center	<b>Street Address, City, State</b>  210 North Main Street, Amity, AR	
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>D5313</b>	<p><b>SPECIMEN SUBMISSION, HANDLING, AND REFERRAL</b> CFR(s): 493.1242(b)</p> <p>The laboratory must document the date and time it receives a specimen.</p> <p>This STANDARD is not met as evidenced by: Through a review of patient final reports and the patient accession log, and through interviews with laboratory staff, it was determined the laboratory failed to document the time it receives a specimen in the laboratory. Survey findings include: A. Through a review of patient final reports it was determined that five of five patient complete blood count final reports (as listed on the patient identification worksheet) failed to include the date or time the laboratory collected or received the patient specimen. B. A review of the patient accession log for January through May of 2018 revealed that the log did not include the time of collection or receipt of the specimen into the laboratory. C. In an interview, at 11:03 on 5/10/2018, laboratory employee #1 (as listed on the form CMS-209) confirmed the laboratory failed to document the time of collection of laboratory specimens.</p>
<b>D5801</b>	<p><b>TEST REPORT</b> CFR(s): 493.1291(a)</p> <p>The laboratory must have an adequate manual or electronic system(s) in place to ensure test results and other patient-specific data are accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to final report destination, in a timely manner. This includes the following: (a)(1) Results reported from calculated data. (a)(2) Results and patient-specific data electronically reported to network or interfaced systems. (a)(3) Manually transcribed or electronically transmitted results and patient-specific information reported directly or upon receipt from outside referral laboratories, satellite or point-of-care testing locations.</p>

This STANDARD is not met as evidenced by:  
Through a review of patient final reports, a review of instrument printouts, and interviews with laboratory staff, it was determined the laboratory failed to ensure test results were accurately sent to the patient medical record on one of five medical records reviewed. Survey findings include: A. The final report dated 1/22/2018 for patient #2477 included a total protein result of 639 with a normal range of 6.4 to 8.1. B. The instrument printout dated 1/22/2018 for patient #2477 included a total protein result of 6.9. C. In an interview, at 11:03 on 5/10/2018, laboratory employee #1 (as listed on the form CMS-209) confirmed that the result documented on the final report in the medical record (reported as 639) was a clerical error and should have been reported as 6.9.