

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 09D2028354	(X3) Date Survey Completed 07/20/2018
Name of Provider or Supplier Laboratory Corporation Of America	Street Address, City, State 2150 Pennsylvania Avenue Suite 1-123, Washington, DC	
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	<p>POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(a)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on the review of records (electronic medical records and the laboratory's test requisition forms) and confirmation by staff interview conducted on July 20, 2018 at approximately 3:00 PM, the laboratory failed to implement an effective quality assessment plan for the post analytic phase of testing to identify the transcription errors for specimen collection times. Three (3) of the four (4) randomly selected patients' electronic medical records revealed erroneous specimen collection times (Accession numbers 199-514-0063, 201-514-0020, 201-514-0010). The findings included: 1. Review of the laboratory's EREQ Allscripts (test requisition form) revealed that a complete Blood Count (CBC) specimen for accession Number (#) 199-514-0063 was collected on 7/18/18 at 2:48 PM. However, review of the CBC result in the patient's electronic medical record revealed that the specimen was collected at 2:48 AM instead of 2:48 PM. 2. Review of the laboratory's EREQ Allscripts for accession #s 201-514-0020 and 201-514-0010 revealed that CBC specimens were collected on 7/20/18 at 8:58 AM and 9:32 AM, respectively. However, review the CBC results in the patients' electronic medical records revealed that the specimens were collected at 12:00 AM. It should be noted that according to staff, when no collection time is entered the system defaults to 12:00 AM. 3. Interview with the laboratory's supervisor revealed that the laboratory has a post-analytic quality assessment plan to review results for randomly selected patients. However, the supervisor was unaware of the erroneous collection times documented for the aforementioned accession numbers.</p>