Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	11D0021848	02/19/2026
Name of Provider or Supplier	**Street Address, City, State**	
Dodge County Hospital Laboratory	901 Griffin Avenue, Eastman, GA	

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
D0000	A Clinical Laboratory Improvement Amendments (CLIA) Recertification Survey was completed on February 19, 2026. The laboratory was not in compliance with applicable CLIA requirements found at 42 CFR 493.1 through 42 CFR 493.1780. The following deficiencies were cited:
D3025	REQUIREMENTS FOR TRANSFUSION SERVICES CFR(s): 493.1103(d) Investigation of transfusion reactions. The facility must have procedures for preventing transfusion reactions and when necessary, promptly identify, investigate, and report blood and blood product transfusion reactions to the laboratory and, as appropriate, to Federal and State authorities. This STANDARD is not met as evidenced by: A review of the Blood Tranfusions & Reactions Procedure, Laboratory Policy #LAB06 (BTRP) and 2025 - 2026 Patient Transfusion Records confirmed that the laboratory SOP failed to define the specific metrics required to initiate transfusion reaction investigations. THE FINDINGS INCLUDE: 1. A review of the BTRP and transfusion records for nine (9) randomly pulled patients, with a total of 18 units transfused, revealed the following: a. Patient MR#1658082 received unit #W038525102801 on September 30, 2025 b. The BTRP pp. 3-4 lists the policy transfusion reactions metrics as: 1. Chilliness 2. Feelings of head fullness 3. Oppressive feelings in patient's chest 4. Sharp pain in lumbar region 5. Distension of neck veins 6. Tachycardia (medically defined as an abnormally fast resting heart rate exceeding 100 beats per minute, often causing palpitations, dizziness, or fainting). 7. Tachypnea (medically defined as rapid, shallow breathing, typically exceeding 20 breaths per minute in adults, often signaling underlying respiratory distress, infection, or anxiety.) 8. Fall in blood pressure and vascular depression c. A review of the patient's transfusion records revealed the following documented patient vitals during transfusion: temperature, pulse rate, respiratory, and blood pressure. d. A review of

	the Blood Transfusion & Reaction Procedure [Lab Policy #LAB06] (BTRP) confirmed that the specific metrics of change in the patient's pulse rate, respiratory rate, or blood pressure that would indicate a potential transfusion reaction was not available. 2. The Technical Supervisor (TS) confirmed that the transfusion records for Patient MR#165808, lacked documentation of the start time or completion time during the transfusion. 3. A review of patient records confirmed that Patient MR#1673116 received unit W038526350369 on February 19, 2026. The transfusion records for this transfusion event lacked documentation of the start time or the completion time. Vitals were documented upon initiation of transfusion with no other vitals documented during the time period of the transfusion. 4. A review of patient records confirmed that Patient MR#1652058 received 3 units: unit #1 (W038525702706) on August 09, 2026 from 12:50 - 13:42; unit #2 (W038525102232) on August 09, 2026 from 11:01 - 12:00; unit #3 (W038525803602) on August 09, 2026 from 12:03 - 12: 35. a. During the transfusion of unit# 1, the patient had a documented pulse rate of 102 at 11:00am; 106 at 11:15am; and 101 at 11:45am. b. During the transfer of unit #3, the patient had a documented pulse rate of 101 at 13:00, c. There was no documentation of Tachycardia on the patiient chart as a transfusion reaction for any of the events. 5. A review of nine (9) random transfusion reports revealed that seven (7) of the nine (9) transfused patients demonstrated erratic blood pressure changes (up to 40mm/Hg change) during the time of transfusion. Documentation of these changes was not available. 6. An exit interview, with the Technical Supervisor, on February 19, 2026 at 04:30pm confirmed that the laboratory SOP failed to define the specific metrics required to initiate transfusion reaction investigations.