Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	17D0450490	02/07/2024
Name of Provider or Supplier	**Street Address, City, State**	
Neosho Memorial Regional Medical Center	629 South Plummer Ave, Chanute, KS	

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	POSTANALYTIC SYSTEMS QUALITY ASSESSMENT CFR(s): 493.1299(a) 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. This STANDARD is not met as evidenced by: Based on the review of the Quality Assurance (QA) plan and Blood Bank policies, lack of post analytical review documentation, review of patients' Electronic Medical Records (EMR) or electronic health record and interview, the laboratory failed to perform post analytical quality assessment to ensure the accurate transfer of patient test information for emergency release of blood and transfusion reactions into the patients' EMR or patient's electronic health record since March 1, 2022 at time of survey. Findings: 1. Review of the "Quality Assurance Plan" and Blood Bank policies revealed no process to ensure nine completed written Emergency Release forms were placed into the patient's EMR or electronic health record. a. A total of fourteen O negative units of red packed cells were emergency released to patients with written Emergency Release forms not entered in the patients' EMR or electronic health record since March 1, 2022. b. There were nine patients receiving blood components with written Emergency Release forms not entered into the patients' EMR or electronic health record since March 1, 2022. 2. Review of the "Quality Assurance Plan" and Blood Bank policies revealed no process to ensure completed written suspected "Transfusion Reaction Investigation" forms were placed into the patient's EMR or electronic health record. a. There are five written pages involved in the "Transfusion Reaction Investigation" form that are completed by nursing, laboratory, physicians, and the pathologist that are not placed in the patient's EMR or electronic health record since March 1, 2022. b. A total of five patients had suspected transfusion reactions with the written "Transfusion Reaction Investigation" forms not entered in the patient's EMR or electronic health record since March 1, 2022. 3. Interview with

	Technical Consultant #3 on February 7, 2024, at 2:00 p.m. confirmed, the laboratory failed to perform post analytical quality assessment to ensure the accurate transfer of patient test information.