

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  17D0452429	<b>(X3) Date Survey Completed</b>  08/07/2025
<b>Name of Provider or Supplier</b>  Clay County Medical Center	<b>Street Address, City, State</b>  617 Liberty Street, Clay Center, KS	
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>D5803</b>	<p>TEST REPORT CFR(s): 493.1291(b)</p> <p>(b) Test report information maintained as part of the patient's chart or medical record must be readily available to the laboratory and to CMS or a CMS agent upon request.</p> <p>This STANDARD is not met as evidenced by: Based on review of the laboratory's "Suspected Transfusion Reaction Investigation" document and electronic medical record (EMR), Cerner, the final patient forms and interview, the laboratory failed to show the State Surveyor (SA) the "Suspected Transfusion Reaction Investigation" document (paper) in the patient's EMR which is the hospital information system (HIS), Cerner. There was not an adequate data entry system(s) review in place that ensured test results were accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to the patient's electronic medical record (EMR). Findings: 1. No information could be provided to the State Surveyor (SA) in patients' EMR of 1 of 1 patient's "Suspected Transfusion Reaction Investigation" paper document at time of survey. 2. There was not an adequate data entry system(s) review in place that ensured test results were accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to the patient's electronic medical record (EMR). 3. Interview with technical consultant #3 on August 7, 2025 at 10:50 a.m. confirmed, the laboratory failed to show the State Surveyor (SA) the "Suspected Transfusion Reaction Investigation" document (paper) in the patient's EMR and have an adequate data entry system(s) review in place that ensured test results were accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to the electronic medical record (EMR).</p>