

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  17D0452807	<b>(X3) Date Survey Completed</b>  06/07/2022
<b>Name of Provider or Supplier</b>  Hospital Dist #1 Of Rice County	<b>Street Address, City, State</b>  619 S Clark, Lyons, 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>D5559</b>	<p>IMMUNOHEMATOLOGY CFR(s): 493.1271(e)(f)</p> <p>(e) Investigation of transfusion reactions. (e)(1) According to its established procedures, the laboratory that performs compatibility testing, or issues blood or blood products, must promptly investigate all transfusion reactions occurring in facilities for which it has investigational responsibility and make recommendations to the medical staff regarding improvements in transfusion procedures. (e)(2) The laboratory must document, as applicable, that all necessary remedial actions are taken to prevent recurrences of transfusion reactions and that all policies and procedures are reviewed to assure they are adequate to ensure the safety of individuals being transfused. (f) Documentation. The laboratory must document all control procedures performed, as specified in this section.</p> <p>This STANDARD is not met as evidenced by: Based on the review of Immunohematology Suspected Transfusion Reaction (TX) reports, electronic medical record (EMR) search, Suspected Transfusion Reactions laboratory procedure, patient vital signs documentation during blood transfusions, post transfusion review notations made by General Supervisor #2 (GS#2) that suspected TX criteria was met but not initiated by transfusing nurse and attending physician, lack of timely remedial action violated laboratory Blood Bank Transfusion Reaction policy to discontinue the transfusion, contact the laboratory and to start suspected TX protocols to ensure patient safety for patient 231256 being transfused. Findings: 1. Review of a "transfusion issue and patient 231256 response report" revealed the transfusion was started on 1/1/22 @ 2:50 am with the patient 231256 temperature of 100.5 Fahrenheit (F) and at 3:20 am the patient's temperature was 102.9 F. 2. Upon the increase of the patient 231256 temperature the nursing protocol for a suspected TX is; nursing to stop infusion immediately, notify patient 23256 physician (physician must order transfusion reaction investigation), the I.V. line kept open with a slow infusion of normal saline, Blood Band notified immediately, the</p>

nurse observing the patient should initiate the Transfusion Reaction Report Form and send the blood bag and infusion set to the laboratory. This protocol was not done immediately on this suspected transfusion reaction of patient 231256. 3. A review of patient 231256 EMR Patient Progress Notes on 1/1/2022 with regards to the transfusion stated the following; a. 1:47 am: Notes:, Temp 100.5 up 2 degrees from 30 min ago. Pt denies any other symptoms. No chilling she said she is just trying to go to sleep. The patient's physician notified. States to continue with blood transfusion. No new orders received. b. 2:50 am: Notes:, started 2nd unit of blood. stayed in her room for 15 min had no reaction and increased to 125ml/hr. c. 3:20 am: Notes:, Oral temp 102.9. Patient's physician notified. Blood stopped at this time. NS @ 125 started. Physician ordered for pt to have Tylenol 1000mg po x1 now and stop blood x 2hrs then restart if temp is under 101. This nurse advised that protocol states this would be considered a "reaction". Pt is having no other signs and symptoms at this time. Also advised that blood can only hang x4 hrs. Orders then given to stop x1 hr re-evaluate and start blood again if the temp is under 101. If above 101 then lab is to be called and then considered a reaction. Orders received for mini cath UA as Dr thinks she could have an underlying infection. d. 4:30 am: Notes:, Lab called as this nurse needed some direction in how to chart times since blood was stopped per Dr orders x1 hr and to advise of temp. Testing Personnel #7 (TP#7) advised she felt it would need to be worked up as a reaction and if Dr ordered that it can be restarted then proceed with Dr orders. Temp currently 100.0 oral. Pt denies any other symptoms. e. 4:40 am: Notes:, Blood transfusion re started at 80cc/hr. Current oral temp 100.0. Will remain at bedside x 15 min to monitor. 4. GS #2 in interview on 6/7/21 at 11:35 am confirmed, the transfusion initiating nurse and patient 231256 physician failed to follow the Transfusion Reaction Investigation protocol with patient 231256 on 1/1/2022 with the increase of the patient's temperature of  $\geq 2$  F. 5. Review of "Transfusion Reaction Investigation" laboratory procedure revealed under "Signs and symptoms that may occur with impending or established transfusion reactions include:" Entered as "Fever, often defined as  $\geq 1$  C or  $\geq 2$  F, with or without chills." 6. GS #2 provided patient 231256 vital signs documentation during the blood transfusion with post transfusion review notations made by patient 231256 nursing staff. 7. Surveyor reviewed documents showed that the transfusing nurse(s) did not initiate a suspected transfusion reaction workup to be completed by the laboratory and the transfusions were completed without intervention. Transfusion date for patient 231256 was on 1/1/2022. 8. Request to review remedial actions taken to avoid recurrence was requested. No documentation was provided during survey prove notification of laboratory director to resume transfusion or if remedial actions were taken. 9. No Corrective Action Plan was provided at survey addressing nursing/physician education on not calling suspected transfusion reactions due to increased temperature. There was no documentation containing any information addressing determination of patient status, notification to patient providers or provider education, or education on the timely communication to the laboratory director when laboratory policies are not followed. 10. GS#2 in an interview on 6/7/22 at 11:35 am confirmed, failed followed established transfusion reaction investigation protocols were taken to ensure patient safety for patient 231256 when being transfused.