

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 17D0648397	(X3) Date Survey Completed 07/22/2025
Name of Provider or Supplier Goodland Regional Medical Center	Street Address, City, State 220 West 2nd St, Goodland, 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
D5401	<p>PROCEDURE MANUAL CFR(s): 493.1251(a)</p> <p>(a) A written procedures manual for all tests, assays, and examinations performed by the laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory's written procedures for testing or examining specimens.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the laboratory procedures and interview with technical consultant #3 (TC#3), the laboratory failed to follow written procedures to perform the suspected transfusion reaction work-up on 1 of 1 patients at the time of survey. Findings: 1. Review of the procedure "Blood Bank Policies" revealed under "Transfusion Reactions" the following: "Signs and Symptoms include chills, shock, lower back pain, pain at infusion site, hives, urticaria, abnormal bleeding, temperature +/- 2 degrees from start, Systolic BP +/- 30 minn from start, Dyastiloc BP +/- 20 mm from start and Heart rate +/- 30 beast from start." 2. One patient with a start systolic of 130 before transfusion, a 163 systolic at the end of transfusion. 3. Incorrect documentation from the Registered Nurse (RN) administering the blood of "No Reaction" and did not contact the provider and the laboratory to initiate a suspected transfusion work-up. 4. The packed red blood cells (PRBCs) was administered 5/4 /2025 @ 9:20 p.m. (2120) and finished 5/4/2025 @ 11:21 p.m. (2321). 5. The Laboratory Director did notice the discrepancy and stated on record a "non-hemolytic reaction" with no suspected reaction work-up. 6. Interview with TC #3 on 7/22/25 at 11:55 a.m. confirmed, the laboratory failed to follow written procedures to perform suspected transfusion reaction work-up on 1 of 1 patients meeting criteria.</p>