

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 17D0690699	(X3) Date Survey Completed 06/16/2021
Name of Provider or Supplier Mcperson Hospital	Street Address, City, State 1000 Hospital Drive, Mcpherson, 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
D5559	<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 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 (GS)#1 that suspected transfusion reaction criteria was met but not initiated by transfusing nurse, lack of timely remedial action documentation and interview, the laboratory failed to document the pathologist interpretation on 2 of 2 suspected transfusion reaction reports in the patients EMR and failed to document that all necessary remedial actions were taken to prevent reoccurrences of the failure to conduct transfusion reaction investigations to ensure patient safety for 4 of 4 patients when being transfused. Findings: 1. Review of 2 of 2 Suspected Transfusion Reaction Reports reveals both listed the pathologist's interpretive comments for the results for the pre-transfusion and post-transfusion specimens tested and clerical checks. 2. Suspected Transfusion Reaction Reports are paper forms. Request was made to see the report in each of the related patients' EMR. 3. An electronic search of both patients' records by the</p>

hospital's Health Information Management staff were unable to produce an electronic copy for 2 of 2 Suspected Transfusion Reaction reports containing the pathologist's interpretive comments for the results for the pre-transfusion and post-transfusion specimens tested and clerical checks. 4. GS #1 in interview on 6/10/21 at 1:40 p.m. confirmed, the laboratory failed to document the pathologist interpretation on 2 of 2 suspected transfusion reaction reports in the patients EMR. 5. Review of "Suspected Transfusion Reactions" laboratory procedure revealed under "The list of signs and symptoms.." Entered as number 2 "Blood Pressure - Arise or drop of 30mm/Hg or more fom the pre-transfusion Blood Pressure." 6. GS #1 provided 5 sets of patient vital signs documentation during 5 blood transfusions with post transfusion review notations made by GS#1. 7. Surveyor reviewed documents for 4 patients who received 5 units (one patient received 2 units). Hand written notations by GS#1 indicated that the suspected transfusion reaction criteria had been met. All 5 sets showed the change in blood pressure of 30mm/Hg or more from pre-transfusion values. Documents also showed that each of the transfusing nurse(s) did not initiate a suspected transfusion reaction workup to be completed by the laboratory and all 5 of the transfusions were completed without intervention. Transfusion dates were as follows: 9/29/2020 (2 units), 1/15/2021, 2/3/21, and 3/19/21. Dates of discovery provided were 10/28/20 for the 9/29/20 event, 2/25/21 for the 1/15/21 and 2/3/21 events and 4/17/21 for the 3/19/21 event. 7. Request to review remedial actions taken to avoid recurrence consisted of entries made into the hospital risk management system on 10/28/2020 for the 9/29/2020 event. The other 3 events were all entered into the hospital risk management system on 4/17/21. No documentation to coordinate with the dates of discovery were provided during survey to assess patient status, notify patient provider or notification of laboratory director. 8. A Corrective Action Plan dated 6/1/21 was provided at survey addressing nursing education on not calling suspected transfusion reactions due to blood pressure. This document did not contain 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. 8. GS#1 in phone interview on 6/16/21 at 3:30 p.m. confirmed, failed to document that all necessary remedial actions were taken to prevent recurrences of the failure to conduct transfusion reaction investigations to ensure patient safety for 4 of 4 patients when being transfused.