Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	17D0984309	08/17/2021
Name of Provider or Supplier	**Street Address, City, State**	
Univ Of Ks Health System - Great Bend Campus, The	514 Cleveland, Great Bend, 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	IMMUNOHEMATOLOGY CFR(s): 493.1271(e)(f) (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. This STANDARD is not met as evidenced by: Based on the review of Immunohematology Suspected Transfusion Reaction reports, electronic medical record (EMR) search, and interview, the laboratory failed to document the pathologist interpretation on 4 of 4 suspected transfusion reaction reports in the patients EMR. Findings: 1. Review of 4 of 4 Suspected Transfusion Reaction Reports revealed each 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 and are scanned to be placed into the patient EMR. Request was made to see the report in each of the related patients' EMR. 3. An electronic search of the patients' records by General Supervisor #4 was unable to produce an electronic copy for 4 of 4 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 #4 in interview on 8/17/21 at 1:05 p.m. confirmed, the laboratory failed to document the pathologist interpretation on 4 of 4 suspected transfusion reaction reports in the patients EMR.
D5805	TEST REPORT CFR(s): 493.1291(c) The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability. This STANDARD is not met as evidenced by: Based on review of patient test reports and interview, the laboratory failed to include the name and address of the laboratory location where the test was performed on the patient report. Findings: 1. Review of selected patient test reports showed the laboratory name and address where the test was performed was not present on the report. 2. Interview with GS#1 on 8/17/21 at 2:35 p.m. confirmed the laboratory failed to include the name and address of the laboratory where the test was performed on the patient report.