

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  23D0369345	<b>(X3) Date Survey Completed</b>  08/21/2019
<b>Name of Provider or Supplier</b>  Trinity Health Iha Medical Group Pediatrics	<b>Street Address, City, State</b>  49650 Cherry Hill Rd Suite 210, Canton, MI	
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>D5821</b>	<p>TEST REPORT CFR(s): 493.1291(k)</p> <p>When errors in the reported patient test results are detected, the laboratory must do the following: (k)(1) Promptly notify the authorized person ordering the test and, if applicable, the individual using the test results of reporting errors. (k)(2) Issue corrected reports promptly to the authorized person ordering the test and, if applicable, the individual using the test results. (k)(3) Maintain duplicates of the original report, as well as the corrected report.</p> <p>This STANDARD is not met as evidenced by: . Based on record review and interview with the office manager, the Technical Consultant (TC), and a office staff member, the laboratory failed to detect an incorrect laboratory test result reported out in the electronic medical record (EMR) for one (#4) of 12 patient charts audited. Findings include: 1. Record review for one (#4) of 12 patient charts audited revealed the final red blood cell (RBC) test result in the EMR system, Testing Personnel #4 (TP4) rounded up the result as follows: RBC 4.28 instrument printout RBC 4.3 in the EMR system 2. During the interview on August 21, 2019 at 11:35 a.m., the office manager, TC, and the office staff member confirmed the final laboratory test report in the patient's EMR record did not match the result reported out on the instrument printout.</p>