Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	25D0318771	09/25/2018
Name of Provider or Supplier	**Street Address, City, State**	
Noxubee General Critical Access Hospital	78 Hospital Road, Macon, MS	

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
D5555	IMMUNOHEMATOLOGY CFR(s): 493.1271(c)(f) (c) Blood and blood products storage. Blood and Blood products must be stored under appropriate conditions that include an adequate temperature alarm system that is regularly inspected. (c)(1) An audible alarm system must monitor proper blood and blood product storage temperature over a 24-hour period. (c)(2) Inspections of the alarm system must be documented. (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 review of blood bank refrigerator continuous-monitoring temperature recorder graphs, blood bank refrigerator temperature logs, and blood bank transfusion records from 10-6-16 through 8-9-18, the laboratory failed to ensure blood was stored under appropriate conditions from 9-12-17 through 11-13-17, when blood was stored for transfusion. Findings include: Review of blood bank refrigerator continuous-monitoring temperature recorder graphs from 10-10-16 through 9-24-18 revealed no temperature recorder graphs from 9-12-17 through 11-13-17. Review of blood bank refrigerator temperature logs from 9-12-17 through 11-13-17 revealed the temperature of the blood bank refrigerator was manually recorded on the logs only once per day, which does not ensure continuous storage under appropriate conditions. Review of blood bank transfusion records revealed blood was stored for transfusion during this time frame.
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 review of the Transfusion Service Testing Record and blood bank reagent quality control (QC) records from 10-6-16 through 8-9-18, the laboratory failed to document performance of quality control for the reagents used for ABO grouping, Rh typing, antibody detection, and compatibility testing for two days during this time frame, when testing was performed on three patients with a total of four units of packed red blood cells (PRBC) issued for transfusion. Findings include: Review of the Transfusion Service Testing Record and blood bank reagent QC records from 10-6-16 through 8-9-18 revealed that quality control for the blood bank reagents was not documented, as performed, on the following days when ABO grouping, Rh typing, antibody detection (Ab screen), and compatibility testing was performed on three patients: 4-6-18--ABO/Rh, Ab screen, and compatibility testing performed on Patient #8667 for one unit of PRBC transfused on 4-6-18; ABO/Rh, Ab screen, and compatibility testing performed on Patient #6610 for one unit of PRBC transfused on 4-6-18. 4-11-18--ABO/Rh, Ab screen, and compatibility testing performed on Patient #6610 for two units of PRBC transfused on 4-11-18.