Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	25D0319447	08/25/2026
Name of Provider or Supplier	**Street Address, City, State**	
Memorial Hosp At Gulfport Path Lab	4500 13th St Box 1810, Gulfport, 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
D0000	An unannounced focused complaint survey was conducted on August 25, 2026, with the following standard-level deficiency cited.
D3023	REQUIREMENTS FOR TRANSFUSION SERVICES CFR(s): 493.1103(c)(2) The facility must establish and follow policies to ensure positive identification of a blood or blood product recipient. This STANDARD is not met as evidenced by: Based on review of facility policies, transfusion educational materials, patient transfusion records, and interviews with facility staff, the facility failed to ensure positive blood product recipient identification for 5 of 10 emergency transfusions. Findings: 1. The facility policy titled "Transfusion of Blood and Blood Products" (Policy# 195.8; Effective date March 1986) stated " ...Procedure ...4. Blood Products are verified by two staff members prior to infusion, one of which must be the RN responsible for the transfusion ...To rapid start a transfusion: To start a Rapid Transfusion click 'Transfusion from the top tool bar, scan patient wristband, Select 'Rapid Start Transfusion' button, Scan from the Donor Blood Bag Label. You are prompted to select 'OK' whenever you are ready to start the transfusion ..." The facility policy did not specify any blood product verification process changes for a "rapid start transfusion". 2. The facility's educational material for transfusionists titled "Transfusion Not as easy as O negative!" stated " ...National Patient Safety Goals ... Eliminate transfusion errors related to patient misidentification 1. Before initiating a blood or blood component transfusion ...Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding. 2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. 3. When using a two-person verification process, the second individual conducting the identification verification is

	qualified to participate in the process, as determined by the hospital ..." Further review of the facility's educational material for transfusionists revealed material titled "Blood Transfusion Memorial Policy 195.8 Blood and Blood Product Transfusion". This material stated " ...Now Let's Go...2 Nurses@ the Bedside ...Verify Patient information on armband against information on the bag of blood. Scan the bag of blood-U format- Bridge performs safety checks. Complete the blood administration record in Bridge answering all questions appropriately ...Scan Bag starting at the left upper bar code and continue scanning using a "U" shape." This educational material failed to address a two-person or one-person verification process. 3. Review of ten emergency release blood transfusions revealed the facility failed to positively identify five blood product recipients: Patient 2013091246 Date of transfusion: 03/26/2026 Packed red blood cells unit number W183626198021 and W183626198025 Only one identifier and no documentation of automated identification. Patient 2013424037 Date of transfusion: 06/17/2026 Packed red blood cells unit number W181226371167; Rapid start Only one identifier and no documentation of automated identification. Patient 2013431854 Date of transfusion: 06/20/2026 Packed red blood cells unit number W180326465846 and W181226408537; Rapid start Only one identifier and no documentation of automated identification. Patient 2013432203 Date of transfusion: 06/20/2026 Packed red blood cells unit number W180326453394 and W181226408614; Rapid start Only one identifier and no documentation of automated identification. Patient 2013467039 Date of transfusion: 06/30/2026 Packed red blood cells unit number W18362618495, W181226355370, and W183626213470; Rapid start Only one identifier and no documentation of automated identification. 4. In an interview on August 25, 2026, in the conference room at 12:30 pm, while reviewing patient transfusion records with the Clinical Informaticist, the Quality Analyst and the Director of Quality, the Clinical Informaticist stated that some of the transfusion records were "rapid transfusions" and did not require a two-person verification. The Quality Analyst was asked to provide a policy for rapid start transfusions that supported that statement. No policy was provided. During patient record review, the Director of Quality stated that if two persons were not available for the verification, the facility used a one-person verification process accompanied by automated identification. The staff were asked to provide documentation of the automated identification. No documentation was provided.