

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  25D0320210	<b>(X3) Date Survey Completed</b>  10/11/2018
<b>Name of Provider or Supplier</b>  Monroe Regional Hospital	<b>Street Address, City, State</b>  400 S Chestnut St, Aberdeen, MS	
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>D5401</b>	<p>PROCEDURE MANUAL CFR(s): 493.1251(a)</p> <p>A written procedures manual for all tests, assays, and examinations performed by the laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory's written procedures for testing or examining specimens.</p> <p>This STANDARD is not met as evidenced by: Based on review of the laboratory blood bank procedure manual, Emergency Transfusion Request form, and confirmation with staff at 10:30 a.m. on the day of survey, 10/11/18, the laboratory did not follow their blood bank procedure during two emergency release situations. Findings include: Review of the Blood Bank records revealed that testing personnel failed to follow the laboratory policy on emergency release of uncrossmatched blood on 2/28/17 and 6/16/17 when 3 units of uncrossmatched packed cells were given to two patients. There was no documentation on the Blood Bank workbook that crossmatches were completed on these units after they were released for transfusion. The Emergency Transfusion Request form states "...routine compatibility testing should be carried out as soon as possible, and the laboratory should report immediately any incompatibility of unit(s) transfused." The procedure in the Blood Bank manual for "Emergency Release of Blood in Urgent Situations" states, When urgent release is requested: 1. Issue uncrossmatched blood, if necessary, and immediately begin crossmatching procedures. 2. Indicate in a conspicuous fashion on the attached tag or label that compatibility testing has not been completed at the time of issue. 3. Complete compatibility testing promptly. If incompatibility is detected at any stage of testing, immediately notify the patient's physician and the Blood Bank Medical Director or Chief Technologist. On 2/18/17 Patient 02000117640 was given 1 unit of Uncrossmatched packed cells (W041617003923)--there was no crossmatch for this unit with this patient documented on the Blood Bank workbook. On 6/16/17 Patient 02000122013 was</p>

given 2 units of Uncrossmatched packed cells (W068517022314, W068517014390)--  
there were no crossmatches for these units with this patient documented on the Blood  
Bank workbook.