Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	32D0714232	12/20/2023
Name of Provider or Supplier	**Street Address, City, State**	
Guadalupe County Hospital	117 Camino De Vida, Santa Rosa, NM	

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 onsite recertification survey conducted on December 20, 2023, at Guadalupe County Hospital, found the laboratory to be in compliance with the CLIA regulations found at 42 CFR, Part 493 Laboratory Requirements, with standard deficiencies cited.
D3025	REQUIREMENTS FOR TRANSFUSION SERVICES CFR(s): 493.1103(d) Investigation of transfusion reactions. The facility must have procedures for preventing transfusion reactions and when necessary, promptly identify, investigate, and report blood and blood product transfusion reactions to the laboratory and, as appropriate, to Federal and State authorities. This STANDARD is not met as evidenced by: Based on a review of facility policy, facility forms, and staff interview, the facility failed to ensure transfusion reaction policies promptly identified transfusion reactions for 3 of 5 patients that received blood products (January 2023 - November 2023). Findings included: 1. Review of the facility's "Standard of Care - Administration of Blood" policy (revised 09/01/2022) stated, "Subject: Standard of Care- Administration of Blood ... 6. Obtain and document vital signs 15 minutes after transfusion begins, and q15 minutes for 1 hour, 1-hour post transfusion ... 8. Watch for signs of blood reaction. 9 ... lower blood pressure, hematuria, chills, pain in lower back and legs, headache, elevated pulse. If transfusion reaction occurs; 1. Stop Transfusion." 2. Review of the facility's Acute Transfusion Reactions form stated "Mild Allergic /Anaphylactic (acute transfusion reactions). Symptoms & Signs: ... drop in blood pressure. Prevention and Tx: STOP TRXN and wait for symptoms to resolve." 3. Review of the facility's blood transfusion form stated " ... Hypotension (drop in systolic BP >/= mmHG from baseline) ... Suspect Possible Transfusion Reaction (if any of the above have been observed) and proceed as follows: 1. Stop Transfusion." 4. A random sampling of the laboratory's blood product administration records revealed the following: a. Patient 0027802 Unit number W041223013636; Packed Red Blood

	Cells Transfusion start date and time: 03/22/2023 at 4:45 pm Transfusion end date and time: 03/22/2023 at 6:40 pm. Pre-transfusion vitals (baseline) documented at 4:45 pm: Pulse 81. BP 125/68 Vitals documentation at 5:00 pm (15 minutes after start of transfusion): Pulse 80. BP 117/68 The patient had a drop in blood pressure from the pre-transfusion vitals. Vitals documentation at 5:15 pm (30 minutes after start of transfusion): Pulse 103. BP 115/56 The patient had an elevated pulse and drop in blood pressure from the pre-transfusion vitals. Per facility policy and facility transfusion forms, a drop in blood pressure and/or an elevated pulse indicated a transfusion reaction. No documentation of a transfusion reaction investigation was provided. b. Patient 0002929 Unit number W041123025053; Packed Red Blood Cells Transfusion start date and time: 06/02/2023 at 10:05 am. Transfusion end date and time: 06/02/2023 at 2:08 pm Pre-transfusion vitals (baseline) documented at 10:02 am Pulse 110. BP 116/75 Vitals documented at 10:50 am (45 minutes after start of transfusion): Pulse 91. BP 102/67 The patient had a drop in systolic blood pressure from the pre-transfusion vitals. Per facility policy and facility transfusion forms, a drop in blood pressure indicated a transfusion reaction. No documentation of a transfusion reaction investigation was provided. c. 8000839 Unit W041223035616; Packed Red Blood Cells Transfusion start date and time: 08/10/2023 at 6:40 pm Transfusion end date and time: 08/10/2023 at 8:40 pm Pre-transfusion vitals (baseline) documented at 6:40 pm: Pulse 96. BP 122/74 Vitals documented at 6:55pm (15 minutes after start of transfusion): Pulse 92. BP 115/75 The patient had a drop in systolic blood pressure from the pre-transfusion vitals. Vitals documented at 7:40 pm (1 hour after start of transfusion): Pulse 106. BP 126/75 The patient had an elevated pulse from the pre-transfusion vitals. Per facility policy and facility transfusion forms, a drop in blood pressure and/or an elevated pulse indicated a transfusion reaction. No documentation of a transfusion reaction investigation was provided. 5. In an interview on 12/20/2023 at 11:45 am, after review of the above records, the General Supervisor confirmed the findings. Word key: Tx = Treatment TRXN = Transfusion BP = Blood pressure mmHG = Millimeters mercury
D6128	TECHNICAL SUPERVISOR RESPONSIBILITIES CFR(s): 493.1451(b)(9) The technical supervisor is responsible for evaluating and documenting the performance of individuals responsible for high complexity testing at least annually after the first year, unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be reevaluated to include the use of the new test methodology or instrumentation. This STANDARD is not met as evidenced by: Based on a review of the laboratory's CMS form 209, competency records, and staff interview, the technical supervisor failed to evaluate annual competencies for 1 of 7 testing personnel (2022 through 2023). Findings included: 1. Review of the laboratory's CMS form 209 revealed testing person (TP) #6, as listed on the CMS for 209, performed high complexity testing. 2. Review of TP #6's 2022 and 2023 competency records list TP #7 as the competency evaluator. The technical supervisor failed to evaluate the annual competency. 3. In an interview on 12/18/2023 at 2:15 pm, after review of the above records, the General Supervisor confirmed the findings.