Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	37D0469490	06/05/2024
Name of Provider or Supplier	**Street Address, City, State**	
Carnegie Tri-County Municipal Hospital	102 N Broadway, Carnegie, OK	

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	The recertification survey was performed on 06/4,5/2024. The laboratory was found in compliance with a standard-level deficiency cited. The findings were reviewed with the technical consultant and testing person #1 at the conclusion of the survey.
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 records, the nursing transfusion policy and interview with the technical consultant, the facility failed to ensure written policies were followed for preventing transfusion reactions for two of five units reviewed. Findings include: (1) On 06/05/2024 at 11:00 am, the technical consultant stated that the laboratory performed transfusion services for emergency release blood and blood products that have been tested by the Oklahoma Blood Institute; (2) The policy "Administration of Blood Products" defined the parameters for ensuring blood products were transfused safely; (3) The surveyor reviewed the policy which stated, "Blood products must be infused within the recommended timeframe to ensure optimal benefit to the patient and due to the risk of bacterial proliferation in the blood component at room temperature. The list below provides the infusion timeframe's for blood products that may be administered"; (a) Red blood cells (RBC's) - within four hours of initiation. (b) Leukocyte-reduced red blood cells (LRBC's) - within four hours of initiation. (4) A review of transfusion records for five units of blood transfused with the technical consultant identified for two of five units transfused, the policy was not followed by nursing personnel: (a) Unit #W091024198498 - The unit was started at 1:58 pm and was completed at 6:10 pm, exceeding the four hour window. (b) Unit

	#W091024123350 - The unit was started at 9:30 am and was completed at 2:10 pm, exceeding the four hour window. (5) Interview with the technical consultant on 06/05 /2024 at 11:00 am confirmed the facility failed to ensure the policy was being followed as written.