STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 430077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

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MONUMENT HEALTH RAPID CITY HOSPITAL	**353 FAIRMONT BLVD POST OFFICE BOX 6000, RAPID CITY, South Dakota, 57701**

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A0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals was conducted from 9/22/26 through 9/23/26. Areas surveyed included nursing services, training and education, emergency responsiveness, patient rights, Quality Assessment and Performance Improvement (QAPI) program, physical environment, medical staff, and provision of services. Monument Health Rapid City Hospital was found not in compliance with the following requirements: A263, A286, A385, A395, A398, and A1117.	A0000		11/18/2026
A0263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is NOT MET as evidenced by: Based on root cause analysis (RCA) review, education and training record review, interview, Quality Assessment and Performance Improvement (QAPI) meeting minutes review, and policy review, the provider failed to ensure its QAPI program effectively implemented and monitored preventive actions following an adverse patient event involving the staff's failure to respond to a patient emergency.	A0263	On 11/10/2026, VP Quality Safety and Risk Management and Director Quality Safety Risk Management met to review the Serious Adverse Event policy. As a process change, the VP Quality Safety and Risk Management or delegate will communicate open Serious Adverse Event investigations to the Quality Assurance and Performance Improvement Committee and Governing Body. Previously, Serious Adverse Event investigations were only reported once closed. The Serious Adverse Event policy was reviewed and education will be completed for Patient Safety and Risk Management Specialists by 11/18/2026. The education includes that, when applicable, widespread corrective actions and education are implemented when identified through the RCA process and that the QAPI and Governing Board reporting process will now include open investigations. The status of education completion will be monitored by the Director Quality Safety and Risk Management and reported to the VP Quality Safety and Risk Management. As a result of the adverse patient event, the following corrective actions were taken: • Hospital-wide education and implementation of a formal nursing orientation verification process for all hospital nursing departments to ensure completion of orientation requirements prior to independent practice • Hospital-wide education regarding emergency response activation, escalation of concerns ("speaking up"), clinical alarm management, assessment and reassessment, documentation, and sedation assessment and medication adjustments	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Pierce	President	11/17/26

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A0263	Continued from page 1 Although the provider identified contributing factors and opportunities for improvement through its RCA, it failed to implement identified corrective measures hospital-wide, communicate lessons learned to applicable staff, communicate the event and identified concerns through QAPI and to the governing body, and monitor the effectiveness of the corrective actions to reduce the risk of recurrence. Cumulatively, these failures showed that the provider's QAPI program failed to implement, communicate, and monitor corrective actions intended to improve patient safety and prevent recurrence of identified concerns, placing patients at risk for similar adverse outcomes. Findings include: 1. Review of the provider's RCA revealed the provider investigated an adverse patient event involving a patient who experienced a significant change in condition while receiving care outside of the intensive care unit (ICU). The RCA identified that the clinical staff failed to initiate an appropriate emergency response when the patient became unresponsive and was not breathing. The RCA further identified that another staff member failed to call for emergency assistance or initiate basic life support (BLS), despite having received BLS training. 2. Following the RCA, the provider failed to implement the identified education hospital-wide, conduct formal audits to monitor the implementation and effectiveness of corrective actions, communicate the identified concerns and corrective actions through the provider's quality and safety committee, or report the event and identified action items to the governing body. Refer to A0286, findings 1-9.	A0263	• Communication of RCA findings and identified corrective actions to the Governing Body on 9/24/2026 for event involving RN A • Beginning with the November QAPI meeting on 11/18/2026, open Serious Adverse Event investigations and the findings of concluded Serious Adverse Event investigations will be reported to QAPI The Director of Quality Safety Risk Management or designee will audit all Serious Adverse Events to ensure that, when applicable, widespread corrective actions and education are implemented when identified through the RCA process and that appropriate reporting to the Governing Body and QAPI occur. Audits will be reported to the VP Quality Safety and Risk Management and continue until 100% compliance is achieved for three consecutive months and at least 10 serious adverse patient events have been reviewed.	
A0385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) report, record review, video event review, observation, interview, and policy review, the provider failed to ensure that	A0385	ICU Department leadership, Human Resources, and Risk Management reviewed video and completed a comprehensive internal investigation including an interview with the involved Registered Nurse (RN). It was determined that the involved RN failed to assess, reassess, intervene, escalate a patient's condition, and respond to an emergency. In addition, documentation review identified discrepancies that did not reflect the patient's condition. As a result of the investigation, RN A's employment was terminated. A comprehensive review of the nursing orientation and competency review process was conducted with hospital (Inpatient, ER, and procedural areas) Nursing Directors, Managers, Nurse Clinicians, Quality personnel, the Vice President (VP) of Nursing, VP Quality Safety Risk Management, and other key stakeholders on November 9 and November 12, 2026. It was determined that a standardized process was needed for all hospital nursing departments to ensure completion of all orientation requirements prior to independent practice.	12/10/2026

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A0385	Continued from page 2 its nursing services provided safe and effective nursing care. Specifically, regarding one of one registered nurse (RN) (A) who failed to appropriately assess, recognize, intervene, escalate, reassess, evaluate, and document care for one of four sampled patients (1) whose nursing documentation did not accurately reflect patient 1's clinical condition, changes in condition, or response to interventions, and did not demonstrate timely recognition, reassessment, escalation, or initiation of an appropriate emergency response when patient 1's condition deteriorated and subsequently expired. In addition, the provider failed to ensure that RN A's required intensive care unit (ICU) competencies were completed, validated, and documented prior to RN A working independently. The cumulative effect of these failures demonstrated that the hospital's nursing service failed to ensure the provision of safe and effective nursing care and placed other patients at risk for delayed recognition and treatment of a medical emergency and similar serious harm. Findings include: 1. Record review, video event review, observations, interviews, and policy review throughout the survey process on 9/22/26 through 9/23/26 revealed that the provider failed to ensure that RN A appropriately supervised, assessed, reassessed, evaluated, and documented the nursing care provided to one of four sampled patients (1). RN A failed to recognize and escalate patient 1's deteriorating condition promptly and failed to initiate an appropriate emergency response. Patient 1 subsequently expired. These failures placed other patients at risk for delayed recognition and treatment of a medical emergency. Refer to A0395, findings 1-11. 2. Interview, employee record review, orientation and competency record review, and policy review revealed that the provider failed to ensure that registered nurse (RN) A's required intensive care unit (ICU) orientation and competencies were completed, validated, and documented prior to RN A working independently. RN A's competency record contained multiple required competencies that were not validated or signed off, and the provider did not verify the completion of the required competencies prior to allowing RN A to work independently. The provider's lack of oversight placed patients at risk of receiving care from RN A, and created the	A0385	As a result, a final orientation verification check-in was incorporated into the nursing orientation process. Upon completion of orientation, the nurse orientee will meet with the Nurse Leader or delegate to evaluate readiness to work independently and verify completion of all required orientation components prior to assuming independent assignment. A standardized final orientation verification document was developed and will be implemented for nurses for all hospital nursing departments on December 10, 2026. Education will be provided to all hospital Nursing Directors, Managers, Nurse Clinicians, and any delegated roles who carry out orientation finalization (such as Clinical Resource Nurses (CRNs) and preceptors) depending on individual unit resources and processes. The education will include expectations, documentation, and verification of the nursing orientation process for all nurses. The education is to be completed by December 9, 2026. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. Any hospital Nursing Director, Manager, Nurse Clinician, or delegated CRN or preceptor who is on leave and has not completed the education by December 9, 2026, will be required to complete the education upon returning to work and prior to participating in the orientation process. A hospital-wide education for initiating emergency response activation, escalation of concerns ("speaking up"), clinical alarm management, assessment and reassessment, documentation, and sedation assessment and medication adjustments was developed for all applicable patient facing hospital staff and will be required to be completed by December 9th, 2026. Any staff who are on leave and have not completed the education by December 9th, 2026 will be required to complete the education upon returning to work and prior to working their next scheduled shift. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. The Nursing Director of the ICU completed a comprehensive review of orientation records of all active ICU RNs who had completed orientation and were practicing independently to ensure competency verification requirements were met. Any incomplete orientee competency checklist identified through this review has been remediated, completed, and validated by the appropriate Nurse Leader or designee to ensure verification and appropriate documentation. This was complete as of 11/13/2026. Each Department Nursing Director or designee will monitor and audit all new nurse orientation records to verify completion of all required orientation components prior to independent practice.	

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A0385	Continued from page 3 potential for changes in a patient's condition to remain unrecognized, unaddressed, or uncommunicated to other members of the healthcare team Refer to A0398, findings 1-6.	A0385	Audits will begin with nurses completing orientation on or after December 10, 2026. The Department Nursing Director will report the audit results to the VP of Nursing, VP of Quality, and Nurse Practice Director until 100% compliance has been achieved for three consecutive months.	
A0286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is NOT MET as evidenced by: Based on root cause analysis (RCA) review, education and training record review, interview, quality meeting minutes review, and policy review, the provider failed to implement preventive actions and mechanisms after completing an RCA of an adverse patient event involving the staff's failure to respond to a patient emergency and failed to implement identified corrective measures hospital-wide, educate to applicable staff, communicate the event and identified concerns through their Quality Assurance and Performance Improvement (QAPI) and to the governing body, and monitor the effectiveness of the corrective actions to	A0286	On 11/10/2026, VP Quality Safety and Risk Management and Director Quality Safety Risk Management met to review the Serious Adverse Event policy. As a process change, the VP Quality Safety and Risk Management or delegate will communicate open Serious Adverse Event investigations to the Quality Assurance and Performance Improvement Committee and Governing Body. Previously, Serious Adverse Event investigations were only reported once closed. The Serious Adverse Event policy was reviewed and education will be completed for Patient Safety and Risk Management Specialists by 11/18/2026. The education includes that, when applicable, widespread corrective actions and education are implemented when identified through the RCA process and that the QAPI and Governing Board reporting process will now include open investigations. The status of education completion will be monitored by the Director Quality Safety and Risk Management and reported to the VP Quality Safety and Risk Management. As a result of the adverse patient event, the following corrective actions were taken: • Hospital-wide education and implementation of a formal nursing orientation verification process for all hospital nursing departments to ensure completion of orientation requirements prior to independent practice • Hospital-wide education regarding emergency response activation, escalation of concerns ("speaking up"), clinical alarm management, assessment and reassessment, documentation, and sedation assessment and medication adjustments • Communication of RCA findings and identified corrective actions to the Governing Body on 9/24/2026 for event involving RN A • Beginning with the November QAPI meeting on 11/18/2026, open Serious Adverse Event investigations and the findings of concluded Serious Adverse Event investigations will be reported to QAPI The Director of Quality Safety Risk Management or designee will audit all Serious Adverse Events to ensure that, when applicable, widespread corrective actions and education are implemented when identified through the RCA process and that appropriate reporting to the Governing Body and QAPI occur. Audits will be reported to the VP Quality Safety and Risk Management and continue until 100% compliance is achieved for three consecutive months and at least 10 serious adverse patient events have been reviewed.	11/18/2026

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A0286	Continued from page 4 reduce the risk of recurrence. Findings include: 1. Review of the provider's root cause analysis (RCA) revealed the provider investigated an adverse patient event involving a patient who experienced a significant change in condition while receiving care outside of the intensive care unit (ICU). The RCA identified that clinical staff failed to initiate an appropriate emergency response when the patient became unresponsive and was not breathing. The RCA further identified that another staff member failed to call for emergency assistance or initiate basic life support (BLS), despite having received BLS training. Further review of the RCA revealed that nursing leadership and the quality, safety, and risk team evaluated registered nurse (RN) training, orientation, competency assessments, and opportunities for improvement. The provider determined that an RN entering the ICU must have at least six months of general care nursing experience before beginning work in the ICU. A newly graduated RN was required to have completed a directed study externship or have nursing assistant experience in the ICU to be eligible for hire. The RCA documented that RN A had worked on the medical unit for approximately nine months before transferring to the ICU. ICU orientation generally lasted six to nine weeks; however, RN A received about eight weeks of ICU orientation. The RCA review showed the provider identified an action item to develop a more formal process for RNs completing orientation. The new process would include a meeting among the RN, preceptor, nurse clinician, and nursing leader to discuss concerns about the RN's readiness to work independently. The RN's personnel file would include meeting documentation and sign-off validation before the RN worked independently. The RCA further identified that computed tomography (CT) staff perceived a hierarchy in which clinical decision-making was deferred to the RN when an RN was present. The hospital identified the need to educate CT staff that, regardless of which healthcare professionals were present, CT staff could independently activate a Code Blue or Rapid Response when a patient was decompensating and required immediate assistance. Additional corrective actions identified through the RCA included "Rescue Anywhere" education on how	A0286		

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A0286	Continued from page 5 staff should activate an emergency response when an emergency occurred in a hallway or while transporting a patient. The education also included initiating BLS and the importance of responding to soft alarms (a yellow alarm indicating a minor deviation in vital signs) by viewing the alarm, assessing the patient, and intervening based on the assessment. Although the provider identified the need for staff education on recognizing and responding to patient emergencies, the provider failed to implement the identified preventive actions hospital-wide. Emergency response education was completed for CT and ICU staff; however, the education was not extended to other staff who provided patient care and were BLS trained. The provider failed to ensure that applicable staff throughout the hospital received the identified "Rescue Anywhere" education regarding how to activate an emergency response when an emergency occurred outside of a patient care unit or while transporting a patient, initiation of BLS, recognition and response to patient deterioration, and staff responsibility to independently activate a Code Blue or Rapid Response when a patient required immediate assistance. The corrective actions were limited to CT and ICU staff and failed to address the potential for a similar patient emergency to occur in other areas of the hospital. 2. Review of the provider's education and training records related to the adverse patient event revealed that the identified emergency response education was completed for CT and ICU staff. No documented evidence showed that the "Rescue Anywhere" education, the importance of responding to alarms, and speaking up and calling a Code Blue or Rapid Response, regardless of an employee's job role, had been provided to other applicable hospital staff who provided patient care and were BLS trained. All ICU RN staff and patient care assistants signed documentation before 8/28/26 indicating they received the required education; however, there was no documented evidence that all CT staff received it. 3. Interview on 9/22/26 at 11:52 a.m. with RN K stated that he recalled receiving the "Rescue Anywhere" education and understood the expectation to immediately activate an emergency response when needed. However, regarding the RCA action item to implement a formal process for nursing leadership to meet with an RN before completing orientation to evaluate the RN's readiness to work independently, RN K stated he was not aware this process was implemented. He	A0286		

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A0286	Continued from page 6 stated, "There is no formal sign-off or a sit-down meeting." 4. Interview on 9/22/26 at 12:20 p.m., CT technologist B stated that after recognizing a change in patient 1's condition on 7/27/26 at 8:22 a.m. following the CT scan, she made the decision to return patient 1 to the ICU due to RN A's lack of response. CT technologist B stated, "I would expect that an ICU nurse knows more than me. I couldn't have done CPR with her; she [RN A] didn't recognize what was happening." CT technologist B acknowledged that she should have activated an emergency response immediately. She stated that, at the time, she believed patient 1 should be returned to the ICU, where additional resources were available. 5. Interview on 9/22/26 at 4:45 p.m. with director of quality, safety, and risk management D stated that no hospital-wide education related to patient 1's adverse event was completed because leadership determined the event was related to the specific actions of RN A. She stated that the CT staff did not receive formal education related to the event until 8/19/26, approximately three weeks after the event occurred. The involved CT staff was not included in discussions about the event or in determining action steps, as she stated, "Their leadership did their own follow-up with them." She stated that no formal audits were conducted to monitor the implementation or effectiveness of the identified corrective actions. She further stated that the adverse event and identified action items were not discussed during the provider's quality and safety meeting held on 8/20/26 or shared with the governing body. Regarding hospital-wide communication of the adverse event for patient 1, she stated that, because of the event's sensitive nature, she had shared information only with the executive leadership team. She was unsure whether the provider's daily safety briefing, which included other hospital departments, had included information related to the adverse event. She stated that, through the RCA process, leadership did not discuss ongoing education related to the identified corrective actions because staff already received annual education on emergency response protocols. Director of quality, safety, and risk management D acknowledged that the RCA process should have included all staff involved in the adverse event. She stated, "We haven't had a situation similar to this before." She further acknowledged that the identified	A0286		

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A0286	Continued from page 7 education and auditing should have been implemented hospital-wide rather than limited to only CT and ICU staff because a similar patient emergency could have occurred in other areas of the hospital. 6. Interview on 9/23/26 at 8:03 a.m. with manager of medical imaging F and director of medical imaging H stated they were not made aware of patient 1's adverse event until they received a notification of the risk event by email. They stated the staff involved in the event did not immediately report it to leadership. Manager of medical imaging F confirmed she was not involved in the RCA process but was later informed of the education that needed to be discussed with the CT staff regarding the event. Manager of medical imaging F stated, "Usually we are included in an RCA if our department was involved, but we weren't in this one. I did not know all the facts or that an RCA was even completed. It would have been helpful to be included." 7. Interview on 9/23/26 at 12:28 p.m. with vice president of nursing G revealed the RCA conducted following patient 1's adverse event did not follow the provider's established RCA process. She stated, "I follow what the risk and safety team suggest, and they did not suggest we provide global education, so we didn't." Vice president of nursing G acknowledged that the RCA should have included all departments involved in the adverse event. She confirmed the event and identified that action items were not shared through QAPI or reported to the governing body. Vice president of nursing G further acknowledged that the identified education should have been implemented system-wide because a similar patient emergency could have occurred in other areas of the hospital. 8. Review of the provider's 8/20/26 Safety and Quality Committee meeting minutes revealed that patient 1's event or associated action items identified were not discussed. 9. Review of the provider's March 2026 Serious Adverse Events policy revealed, "In order to assist the Hospital in monitoring, evaluating, and taking actions to improve the quality of care provided to patients and/or to correct any deficiencies in services provided by personnel or equipment, and in order to report potential claims to its liability carrier and investigate them in anticipation of litigation, Serious Adverse Events (SAEs) will be reported internally and a root cause analysis of the event will be completed."	A0286		

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A0286	Continued from page 8 The policy further described the RCA process and directed that a multidisciplinary team include representation from involved departments, medical staff, or general counsel, as applicable. The policy required reporting process changes to leadership and required action plans to identify the responsible person, follow-up dates, and measurements used to determine success. The policy further directed, "Any process changes which are implemented will be monitored to document improvement."	A0286		
A0395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) report, record review, video event review, interview, and policy review, the provider failed to ensure that one of one registered nurse (RN) (A) appropriately supervised, assessed, reassessed, evaluated, and documented the nursing care provided to one of four sampled patients (1). RN A failed to recognize and respond to patient 1's change in condition and initiate an appropriate emergency response when patient 1 became unresponsive and was not breathing. Findings include: 1. Review of patient 1's electronic medical record (EMR) revealed the patient was admitted on 7/24/26 from the emergency department (ED) to the intensive care unit (ICU) after being found at home with ane altered mental status (a change in awareness, thinking, or responsiveness) and suspected syncope (fainting or passing out). A computed tomography (CT) scan of the head showed evidence of a traumatic skull fracture, bifrontal hemorrhagic contusions (areas of bruising and bleeding in the front portions of the brain), bilateral subdural hematomas (collections of blood between the brain and its outer covering on both sides of the head), bifrontal subarachnoid hemorrhage (bleeding in the space surrounding the front portions of the brain), and a right occipital bone fracture (a fracture of the bone at the back of the skull) that extended into the right temporal bone (the bone on the side of the skull). On 7/27/26, patient 1 was scheduled for a CT scan of the head. Due to patient 1's restlessness,	A0395	ICU Department leadership, Human Resources, and Risk Management reviewed video and completed a comprehensive internal investigation including an interview with the involved Registered Nurse (RN). It was determined that the involved RN failed to assess, reassess, intervene, escalate a patient's condition, and respond to an emergency. In addition, documentation review identified discrepancies that did not reflect the patient's condition. As a result of the investigation, RN A's employment was terminated. A comprehensive review of the nursing orientation and competency review process was conducted with hospital (Inpatient, ER, and procedural areas) Nursing Directors, Managers, Nurse Clinicians, Quality personnel, the Vice President (VP) of Nursing, VP Quality Safety Risk Management, and other key stakeholders on November 9 and November 12, 2026. It was determined that a standardized process was needed for all hospital nursing departments to ensure completion of all orientation requirements prior to independent practice. As a result, a final orientation verification check-in was incorporated into the nursing orientation process. Upon completion of orientation, the nurse orientee will meet with the Nurse Leader or delegate to evaluate readiness to work independently and verify completion of all required orientation components prior to assuming independent assignment. A standardized final orientation verification document was developed and will be implemented for nurses for all hospital nursing departments on December 10, 2026. Education will be provided to all hospital Nursing Directors, Managers, Nurse Clinicians, and any delegated roles who carry out orientation finalization (such as Clinical Resource Nurses (CRNs) and preceptors) depending on individual unit resources and processes. The education will include expectations, documentation, and verification of the nursing orientation process for all nurses. The education is to be completed by December 9, 2026. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. Any hospital Nursing Director, Manager, Nurse Clinician, or delegated CRN or preceptor who is on leave and has not completed the education by December 9, 2026, will be required to complete the education upon returning to work and prior to participating in the orientation process.	12/10/2026

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A0395	Continued from page 9 intravenous (IV) Versed (a medication used to cause relaxation and sedation), Haldol (a medication used to reduce severe agitation or confusion), and Ketamine (a medication used for sedation and pain control) were prescribed prior to the CT scan. Patient 1 was also on a continuous ketamine infusion. RN A administered 2 milligrams (mg) of IV Versed at 7:45 a.m., and 10 mg of IV Haldol at 8:00 a.m. The last documented vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) on 7/27/26 at 7:00 a.m. were a heart rate (HR) of 72 beats per minute (bpm), respirations of 21, a blood pressure (BP) of 128 systolic over 75 diastolic, and an oxygen saturation (percentage of oxygen in the blood) reading of 95% (percent) on room air (no supplemental oxygen delivered). Prior to leaving the ICU for the CT scan, RN A did not document a physical assessment. On 7/27/26 at 7:00 a.m., RN A documented a Richmond Agitation-Sedation Scale (RASS) (a scale that measures a patient's level of alertness and agitation) score of -1 (indicating drowsy, patient not fully awake, but has sustained awakening to voice). At 8:00 a.m., RN A documented a RASS of -3 (indicating moderate sedation with movement or eye opening to voice, but no eye contact). The ketamine infusion order directed the staff to, "STOP ketamine infusion immediately and call the provider if the Richmond Agitation Sedation Scale (RASS) is -3, -4, -5, apnea (not breathing), or the respiratory rate is less than 6." Despite the documented RASS score of -3, the ketamine infusion was not stopped until 9:18 a.m. In addition, RN A administered 50 mg of IV Ketamine to patient 1 in the CT room at 8:15 a.m. RN A transported patient 1 from the ICU to the CT department at 8:04 a.m., accompanied by a transport aide, and patient 1 was connected to a transport monitor that recorded vital signs. Patient 1 remained in the CT department until 8:24 a.m. and returned to the ICU at 8:27 a.m. A Code Blue (life-threatening medical emergency) was called at 8:29 a.m. in the ICU. The Code Blue ended at 8:49 a.m. after 11 minutes of cardiopulmonary resuscitation (CPR). From 8:00 a.m. to 8:52 a.m., no vital signs were documented in patient 1's EMR. A nursing note entered on 7/27/26 at 1:30 p.m. by RN A indicated patient 1 was scheduled for a CT scan and orders were received for sedation medication prior to the CT scan. RN A documented, "Prior to leaving for CT, 2 mg Versed given IV, [it had] minimal effect, pt [patient 1] still pulling at lines	A0395	A hospital-wide education for initiating emergency response activation, escalation of concerns ("speaking up"), clinical alarm management, assessment and reassessment, documentation, and sedation assessment and medication adjustments was developed for all applicable patient facing hospital staff and will be required to be completed by December 9th, 2026. Any staff who are on leave and have not completed the education by December 9th, 2026 will be required to complete the education upon returning to work and prior to working their next scheduled shift. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. The Nursing Director of the ICU completed a comprehensive review of orientation records of all active ICU RNs who had completed orientation and were practicing independently to ensure competency verification requirements were met. Any incomplete orientee competency checklist identified through this review has been remediated, completed, and validated by the appropriate Nurse Leader or designee to ensure verification and appropriate documentation. This was complete as of 11/13/2026. Each Department Nursing Director or designee will monitor and audit all new nurse orientation records to verify completion of all required orientation components prior to independent practice. Audits will begin with nurses completing orientation on or after December 10, 2026. The Department Nursing Director will report the audit results to the VP of Nursing, VP of Quality, and Nurse Practice Director until 100% compliance has been achieved for three consecutive months.	

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A0395	Continued from page 10 and agitated. Once in CT, 10 mg Haldol given prior to first scan. By [the] end of [the] first scan pt [patient 1] was becoming agitated and moving. 50 mg Ketamine given and pt [patient 1] remained still for second scan. After CT [was] completed, pt [patient 1's] looked pale. When transferred to [the] bed from [the] CT table, pt [patient 1] head was elevated and pt's [patient 1] color was normal. Breathing was at baseline, HR was in the 70's. Due to now transport, radiology assisted with transport back to [patient 1's] room. Upon returning to [the] 5th floor, pt [patient 1] was bradycardic [slow heart rate], respirations still the same. In room pt [patient 1] stopped breathing, HR was barely palpable. Code [Blue] called." Further review of patient 1's EMR revealed a repeat CT scan was completed and showed a global anoxic brain injury (brain injury caused by a lack of oxygen). The provider transferred patient 1 to another hospital on 8/3/26 for organ procurement. 2. Review of provider's video footage of patient 1's adverse event on 7/27/26 revealed at 8:04 a.m., patient 1, accompanied by RN A, exited the ICU on the fifth floor and entered the hallway toward the elevator. Patient 1 appeared alert and responsive and was observed moving both arms. From 8:06 a.m. to 8:07 a.m., RN A and patient 1 exited the elevator on the second floor. Patient 1 appeared alert, moved their extremities, and conversed with the staff. At 8:10 a.m., RN A and patient 1 arrived in the radiology department and entered the CT scan room. At 8:22 a.m., the door to the CT scan room opened. At 8:24 a.m., RN A, CT technologist B, and medical imaging assistant C exited the CT scan room with patient 1. CT technologist B pushed patient 1's bed while RN A opened the doors with her badge. The transport monitor was positioned on the bed facing RN A. Patient 1 was not observed moving or responding, and the patient's skin color appeared gray and pale. At 8:26 a.m., RN A, CT technologist B, and medical imaging assistant C entered the elevator on the second floor with patient 1. At 8:27 a.m., the staff exited the elevator on the fifth floor and proceeded toward the ICU. The vital signs displayed on the transport monitor were difficult to read on the video footage; however, the monitor appeared to display question marks, and a yellow alarm was observed flashing. Patient 1 appeared pale, was not observed moving or breathing, and did not appear responsive. RN A was not observed assessing patient 1 at any time during transport from the CT department to the	A0395		

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A0395	Continued from page 11 ICU. The staff continued transporting patient 1 to the ICU, and no emergency response was observed to have been initiated during transport. 3. Interview on 9/22/26 at 9:32 a.m. with charge nurse L revealed she was working in the ICU on the morning of 7/27/26. Charge nurse L stated patient 1 went to the CT department and became unresponsive while there. The staff decided to transport patient 1 back to the ICU rather than call a Code Blue in the CT department. Charge nurse L stated that when patient 1 returned to the ICU, another charge nurse noticed CT technologist B pushing the bed, which was not standard procedure. Patient 1's pulse oximeter (a device that estimates the percentage of oxygen in the blood) was not registering any data. RN A checked patient 1 for a pulse, and patient 1 was unresponsive and not breathing. A Code Blue was then called. Charge Nurse L stated that RN A was reassigned following the event because RN A was "unprepared, not having had a patient like this before." Charge Nurse L would have expected RN A to assess patient 1 and call for help immediately if patient 1 wasn't breathing or had no pulse. 4. Interview on 9/22/26 at 10:47 a.m. with director of ICU E revealed she became aware of patient 1's 7/27/26 adverse event approximately one week later because she had been on vacation at the time of the event. ICU manager I had reported the event to leadership and completed a follow-up with the nursing staff, the physician, and the charge nurse. Director of ICU E stated that after she reviewed the video footage of the event, she immediately contacted human resources (HR) staff, vice president of nursing G, and the quality, safety, and risk team. Director of ICU E stated, "After reviewing the video footage, there was definitely a change in the patient's condition. The patient was unresponsive, not moving, and had a change in skin color. The patient needed help." Following discussions with leadership and HR, the decision was made to terminate RN A's employment. Director of ICU E stated RN A had completed approximately eight weeks of orientation in the ICU, and there was no identified concerns regarding RN A's clinical skills or abilities during her orientation. Director of ICU E stated she regularly checked in with the new nursing staff, and RN A had expressed feeling uncomfortable with the pace in the ICU. Director of ICU E stated this was common for staff transitioning into the ICU, and preceptors would continue working with the new staff to build their confidence. Director of ICU E further stated RN A's	A0395		

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A0395	Continued from page 12 clinical orientation competency checklist was not reviewed for completeness or placed in RN A's employee file. Nurse clinicians assist in completing the competency checklists. The provider was trialing the transition of the paper competency checklist to an online format. Director of ICU E stated she was unaware of what portions of RN A's competency checklist, if any, were completed in the online format, but that it should have been completed and placed in her employee file. 5. Interview on 9/22/26 at 12:20 p.m. with CT technologist B revealed she was familiar with patient 1 prior to the scheduled CT scan on 7/27/26 because patient 1 had previously been brought to the CT department and was anxious, restless, and had difficulty following commands. CT Technologist B stated she was informed that RN A would administer sedation medications before patient 1 arrived in the CT department for the 7/27/26 CT scan. CT technologist B stated that when patient 1 arrived in the CT department that morning, patient 1 had his hand over his head. RN A administered a medication prior to coming to CT scan and subsequently administered ketamine. The staff transferred patient 1 to the CT table. Patient 1 was still responsive but began to relax. CT Technologist B stated that no alarms were sounding from the patient's monitor. After the CT scan was completed, CT technologist B observed that patient 1's facial color was "bluish/purple." She called out to RN A and stated, "We have a problem." The staff transferred patient 1 from the CT table back to the hospital bed. CT technologist B asked RN A, "Do we need to do something?" CT technologist B stated she asked RN A three times if they needed help, but RN A did not respond. CT technologist B looked at the monitor and observed a heart rate of 38 beats per minute. RN A checked patient 1 for a carotid pulse for approximately 10 seconds but did not say anything. RN A then checked for a radial pulse and again did not respond. CT technologist B stated, "I made the decision to go back to the room. I trust that an ICU nurse knows more than me. I'm moving as fast as I can. I couldn't do CPR with her [RN A]; she [RN A] didn't recognize what was happening." She stated that when they arrived in the ICU, she checked patient 1 for a pulse and could not detect one. The ICU charge nurse arrived, and a Code Blue was called. CT technologist B agreed that a Code Blue or Rapid Response should have been called while patient 1 was in the CT department. CT technologist B	A0395		

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A0395	Continued from page 13 confirmed she was trained in basic life support (BLS). 6. Interview on 9/22/26 at 12:50 p.m. with medical imaging assistant C revealed he was called into the CT department on 7/27/26 to assist CT technologist B with transferring patient 1 from the CT table back to the hospital bed. Medical imaging assistant C stated, "His [patient 1] face was discolored." Medical imaging assistant C stated CT technologist B asked RN A if patient 1 was okay, but RN A did not respond. CT technologist B decided to transport patient 1 back to the ICU because RN A was not providing direction to them. Medical imaging assistant C stated that patient 1's monitor displayed a "yellow" alarm, and RN A stated, "My monitor is not working." Medical imaging assistant C stated the oxygen saturation monitor was not providing a reading. Medical imaging assistant C stated that after the staff arrived in the ICU with patient 1, the charge nurse entered the room, CT technologist B checked patient 1 for a pulse, and a Code Blue was called. Medical imaging assistant C confirmed that basic life support (BLS) training was not required for his role and that he relied on the nursing staff to respond and provide direction during emergencies. 7. Interview on 9/23/26 at 9:30 a.m., ICU Manager I confirmed that the vital sign data collected by the transport monitor while patient 1 was in the CT department was lost because the data was not transferred from the transport monitor after patient 1 returned to the ICU. ICU manager I stated that staff were expected to transfer the patient's vital sign data collected during transport from the transport monitor into the EMR. 8. Review of the provider's April 2026 Interdisciplinary Assessment and Reassessment policy revealed, "If the patient is off the unit for an anticipated test or procedure during the time the vital signs would normally be taken, they can be taken prior to the patient leaving the unit. If not taken, the vital signs should be taken as soon as possible when the patient returns with a comment indicating the reason for delay." The policy directed the RN to reassess a patient when the patient's condition or status changed. The policy directed ICU patients to be reassessed more frequently based on their condition, with vital signs documented at least hourly or more often when clinically indicated. 9. Review of the provider's March 2026 Transport: Intrahospital Care Requirements policy revealed, "All	A0395		

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A0395	Continued from page 14 ICU patients should have a minimum monitoring of pulse oximetry, ECG [electrocardiogram] and regular measurement of blood pressure and respiratory rate." The policy required an RN to accompany all ICU patients during transport and required documentation of the patient's status and monitoring while away from the unit when the patient experienced hemodynamic instability (unstable blood pressure or circulation). 10. Review of the provider's November 2024 Rapide Response Team-Adult policy revealed, "Any person may summon the Rapid Response Team (RRT) toe assist in the care of a patient or visitor who has a deteriorating status or presents with early warninge signs of a status change, and is not ine cardiopulmonary arrest." The policy identifiede indications for activation of the RRT, including a heart rate less than 40 beats per minute, changes in oxygen saturation or level of consciousness, or when a staff member was concerned about thee patient's status or requested assistance with ane assessment.e 11. Review of the provider's November 2026 Codee Blue policy revealed, "It is the discretion of thee attending physician or primary nurse to activate the Code Blue response in any area when additional staff members are needed to provide quality resuscitative care."	A0395		
A0398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is NOT MET as evidenced by: Based on interview, employee record review, orientation and competency record review, and policy review, the provider failed to ensure that one of one registered nurse (RN) (A)'s required intensive care unit (ICU) orientation and competencies were completed, validated, and documented prior to RN A working independently. Findings include:	A0398	ICU Department leadership, Human Resources, and Risk Management reviewed video and completed a comprehensive internal investigation including an interview with the involved Registered Nurse (RN). It was determined that the involved RN failed to assess, reassess, intervene, escalate a patient's condition, and respond to an emergency. In addition, documentation review identified discrepancies that did not reflect the patient's condition. As a result of the investigation, RN A's employment was terminated. A comprehensive review of the nursing orientation and competency review process was conducted with hospital (Inpatient, ER, and procedural areas) Nursing Directors, Managers, Nurse Clinicians, Quality personnel, the Vice President (VP) of Nursing, VP Quality Safety Risk Management, and other key stakeholders on November 9 and November 12, 2026. It was determined that a standardized process was needed for all hospital nursing departments to ensure completion of all orientation requirements prior to independent practice.	12/10/2026

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A0398	Continued from page 15 1. Interview on 9/22/26 at 10:47 a.m. with director of intensive care unit (ICU), E, revealed that RN A had transferred to the ICU from the medical unit, where she had worked for approximately nine months. RN A had completed approximately eight weeks of orientation in the ICU prior to working independently. At the time of patient 1's event on 7/27/26, RN A was working independently in the ICU for approximately four weeks. Director of ICU E stated RN A's preceptors had felt comfortable with her abilities and progression during orientation, and RN A did not express concerns to her preceptor. Director of ICU E stated RN A's clinical orientation competency checklist was not reviewed for completeness or placed in RN A's employee file. The provider was trialing the transition of the paper competency checklist to an online format. Director of ICU E stated she was unaware of what portions of RN A's competency checklist, if any, were completed in the online format. At the time of the interview, they could not find RN A's competency checklist. Director of ICU E agreed RN A's competency checklist should have been completed and submitted. 2. Interview on 9/22/26 at 11:52 a.m. with RN K revealed he had served as one of RN A's preceptors during her eight weeks of ICU orientation. RN K stated RN A had progressed as expected regarding patient care, problem-solving, and discussion of mock scenarios for situations that may not have been encountered during orientation. RN K stated he had completed RN A's competency validation checklist in the online portal rather than on paper. RN K was unsure whether all required competencies were completed and signed off or whether the completed documentation was submitted to RN A's employee file. 3. Interview on 9/23/26 at 1:18 p.m. with ICU manager J revealed the transition from the paper competency validation checklist to an online format for staff was a "trial and error" process. ICU manager J stated that the online version of the competency checklist did not adequately support the competency validation process in the ICU. ICU manager J confirmed there was no verification or cross-check to ensure all nurse competencies listed on the paper checklist had been transferred to the electronic format. ICU manager J stated that if RN A's required competencies were not completed and signed off prior to RN A working independently, documentation should have been present to identify the reason the competencies remained incomplete.	A0398	As a result, a final orientation verification check-in was incorporated into the nursing orientation process. Upon completion of orientation, the nurse orientee will meet with the Nurse Leader or delegate to evaluate readiness to work independently and verify completion of all required orientation components prior to assuming independent assignment. A standardized final orientation verification document was developed and will be implemented for nurses for all hospital nursing departments on December 10, 2026. Education will be provided to all hospital Nursing Directors, Managers, Nurse Clinicians, and any delegated roles who carry out orientation finalization (such as Clinical Resource Nurses (CRNs) and preceptors) depending on individual unit resources and processes. The education will include expectations, documentation, and verification of the nursing orientation process for all nurses. The education is to be completed by December 9, 2026. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. Any hospital Nursing Director, Manager, Nurse Clinician, or delegated CRN or preceptor who is on leave and has not completed the education by December 9, 2026, will be required to complete the education upon returning to work and prior to participating in the orientation process. A hospital-wide education for initiating emergency response activation, escalation of concerns ("speaking up"), clinical alarm management, assessment and reassessment, documentation, and sedation assessment and medication adjustments was developed for all applicable patient facing hospital staff and will be required to be completed by December 9th, 2026. Any staff who are on leave and have not completed the education by December 9th, 2026 will be required to complete the education upon returning to work and prior to working their next scheduled shift. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. The Nursing Director of the ICU completed a comprehensive review of orientation records of all active ICU RNs who had completed orientation and were practicing independently to ensure competency verification requirements were met. Any incomplete orientee competency checklist identified through this review has been remediated, completed, and validated by the appropriate Nurse Leader or designee to ensure verification and appropriate documentation. This was complete as of 11/13/2026.	

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A0398	Continued from page 16 4. Review of RN A's employee record revealed documentation of RN licensure verification, basic life support (BLS) training, advanced cardiac life support (ACLS) training, and a 2025 performance evaluation that indicated RN A had met the provider's expectations. 5. Review of RN A's 9/1/24 through 10/1/26 online assessment and competency orientation checklist revealed multiple required skills were not validated or signed off by a preceptor. No documentation supported that the identified skills were discussed or evaluated, or that RN A was unable to demonstrate the skills during orientation. Examples of competencies that were not validated and signed off during training in the ICU included telemetry monitoring, physical assessment, clinical alarm management, Code Blue management, and cardiac arrest. 6. Review of the provider's January 2026 New Employee Orientation policy revealed department orientation should include information specific to the department and job function. Department leaders were responsible for ensuring new and transferring staff completed required department-specific orientation and determining if additional training was needed before orientation was completed.	A0398	Each Department Nursing Director or designee will monitor and audit all new nurse orientation records to verify completion of all required orientation components prior to independent practice. Audits will begin with nurses completing orientation on or after December 10, 2026. The Department Nursing Director will report the audit results to the VP of Nursing, VP of Quality, and Nurse Practice Director until 100% compliance has been achieved for three consecutive months.	
A1117	STAFF TRAINING CFR(s): 482.55 (c)(3), (c)(3)(i)(ii)(iii)(iv) Applicable staff, as identified by the hospital, must be trained annually on the protocols and provisions implemented pursuant to this section. (i) The governing body must identify and document which staff must complete such training. (ii) the hospital must document in the staff personnel records that the training was successfully completed. (iii) the hospital must be able to demonstrate staff knowledge on the topics implemented pursuant to this section This STANDARD is NOT MET as evidenced by: Based on interview, observation, policy review, standard work review, the provider failed to ensure a standardized and consistently understood process for initiating a code blue (life-threatening medical emergency) in one of one computed tomography (CT) department. Findings include:	A1117	On November 11, 2026, the Code Blue Committee Chair, Director of Medical Imaging, Emergency Department (ED) Director, and other key stakeholders met to review the process for emergency response activation in the Computed Tomography (CT) department and to determine a standardized consistent process. It was determined the CT department will follow the hospital-wide emergency response process including activation of a Code Blue through the designated Code Blue button or initiation of a Rapid Response by calling 53111. Education will be provided to all Medical Imaging staff through email and daily huddles with verbal confirmation with their leader of receipt of the information. The education included the updated standard process in CT for calling a Code Blue or Rapid Response to include recognition of an emergency and the responsibility of speaking up. Any staff who is on leave and has not completed the education by December 9th, 2026 will be required to complete the education upon returning to work and prior to working their scheduled shift.	12/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 430077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1117	Continued from page 17 1. Interview on 9/22/26 at 12:20 p.m. with CT technologist B revealed there were different ways to call a code blue depending on whether the patient resided in a patient room within the hospital or was from the emergency department (ED). She thought the process of calling a code blue was confusing and was not sure where the crash cart (specialized, mobile cart filled with lifesaving drugs, medication, and tools) was located. She was not trained in mock code blue drill. 2. Interview on 9/22/26 at 12:50 p.m. with medical imaging assistant C revealed he had worked for the provider for seven years and could not remember if code blue training was part of his orientation. He had taken part in the department's 2026 code blue training. He said there were different ways to call a code blue depending on if the patient was an inpatient in the hospital or from the ED. He said the staff called a phone number if it was an inpatient but would have hit the code blue button located on the wall if the patient was from the ED. He stated the nearest crash cart was in the ED and he believed the ED personnel would bring it to the CT room during a code blue. 3. Interview on 9/22/26 at 1:06 p.m. with director of medical imaging H revealed the different processes to call a code blue depending on the patient's ED or inpatient status was only used in the CT rooms by the ED. He believed the other imaging departments used a different process. He was not sure whose responsibility it was to retrieve the crash cart during a code blue. He thought the number to call a code blue was programmed into the department's phones located next to the CT control panels. Further observation and interview on 9/22/26 at 1:20 p.m. of the emergency department CT control booths for CT 3, CT 4, and ED imaging rooms with director of medical imaging H revealed there was a phone located at the control panel for each room and a blue code call button mounted on the wall next to them. He verified the call number for the inpatients was only programmed into the phone at CT3's control panel. Further interview on 9/22/26 at 4:20 pm. with director of medical imaging H revealed the process for calling a code blue described by CT technologist B and medical imaging assistant C was not included in the hospital's code blue call process. 4. Interview on 9/23/26 at 8:04 a.m. with manager of medical imaging F and director of medical imaging H revealed they had two different code blue call	A1117	A hospital-wide education for initiating emergency response activation, escalation of concerns ("speaking up"), and clinical alarm management was developed for all applicable patient facing hospital staff and will be required to be completed by December 9th, 2026. The status of education completion will be monitored by the Department Directors and reported to the respective VP and the VP Quality Safety Risk Management. Any patient facing staff who is on leave and has not completed the education by December 9th, 2026 will be required to complete the education upon returning to work and prior to working their scheduled shift. The Director of Medical Imaging or designee will conduct 5 audits via staff interview per week (20 audits per month) to ensure staff understanding of the standardized Code Blue and Rapid Response initiation process. Audits will continue until 100% compliance has been achieved for three consecutive months. Additionally, the Code Blue committee will conduct a Code Blue simulation in CT scheduled for December 16, 2026. Audit results will be reported to the VP of Quality Safety Risk Management, VP of Operations, and Associate VP of Laboratory and Imaging monthly.	

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A1117	Continued from page 18 processes for the CT rooms near the ED. The process was included in the standard work calling for codes policy. They were doing competencies for this process for all their staff. They stated that calling a code blue was a broken process within their department. 5. Interview on 9/23/26 at 9:56 a.m. with CT technologist M related to code blue revealed that if the patient was an ED patient they called the ED to call the code blue. The CT phone had the ED contact number programmed into it. He stated that he would normally call the ED department at 58222. There was also a speed dial number to call a code blue for inpatients. He thought it would be less confusing to have one consistent number to call. He was not aware that they needed to grab a vitals'- monitor from the ED for inpatients or outpatients. 6. Interview on 9/23/26 at 10:10 a.m. with senior CT technologist N revealed he would have pushed the code blue button on the wall during an emergency. He was not sure where the buttons were in the CT rooms near the ED. He said you could also call 3111 for a code blue. 7. Interview on 9/23/26 at 10:50 a.m. with manager of medical imaging F and director of medical imaging H revealed they agreed they needed to review their code blue policies since the CT staff members were confused about the process. 8. Review of the provider's November 2024 Code Blue Process policy revealed a code blue could be activated by calling 3111 or by pushing the code blue buttons. The staff member would need to tell the operator it was a code blue, the location of the code blue, and whether the patient was a child or adult. There was no mention of a different process in the CT rooms near the ED. 9. Review of the provider's 4/30/26 Calling Codes in the ED standard revealed there were two processes of calling a code in the ED. The processes depended on the patient's class. The staff member should use the phone next to CT3 and press the overhead speed button for ED patients. The staff member should dial 53111 posted on all phones in ED CT 3 or 4 for inpatients or outpatients. The CT staff member should retrieve a vitals' monitor from the ED. If the staff member was the only one in the CT department, they could push the code blue call button.	A1117		