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A 000	INITIAL COMMENTS A complaint survey for complaint # 2022012553 was conducted on . . . . . through . . . . . at HCA Florida Blake Hospital. The facility was not in compliance with CFR 482.13, CFR 482.21, and CFR 482.23. An Immediate Jeopardy (IJ) was identified beginning on . . . . . at 12:45 PM. The Vice President of Quality and Patient Safety was notified of Immediate Jeopardy on . . . . . at 4:00PM. The facility failed to recognize a change in . . . . . rhythm and escalate process of notification resulting in a patient . . . . Refer to Tag A144 The facility failed to provide immediate nursing care for a patient with a change in . . . . rhythm on telemetry monitoring resulting in the patient's . . . . Refer to tag A0392. The facility failed to provide qualified nursing personnel for telemetry monitoring. Refer to tag A0397. These . . . . placed the patients on telemetry monitoring at risk of injury or . . . due to unidentified . . . . . and resulted in the Condition of Participation being out of compliance. The . . . . . effect of these systemic failures resulted in the identification of Immediate Jeopardy for those patients on . . . . . telemetry.	A 000		

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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 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.

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An Immediate Jeopardy action removal plan provided by the facility on which included:

All telemetry staff are required to review the telemetry monitoring process regarding audible alarms and be validated on current shift and prior to any oncoming staff working their shift. Completed with staff onsite and observed by surveyors. Education for additional staff prior to working is ongoing. Review of documentation and attestation of staff was completed.

telemetry monitoring was moved to central telemetry visible to telemetry technicians, completed . Observation of telemetry monitoring room was done, monitors moved to areas where staff are currently monitoring other units. Observation of patients with alarms not silenced completed.

Alarms turned on for ST elevation on telemetry monitoring and staff oriented to change. Alarm change completed onsite . Education ongoing. Verification with telemetry staff completed.

Tracking of staff signing into the hospital provided phones to receive telemetry alerts. Reports verified by surveyor. Monitoring ongoing. Review of current staff not signed into hospital provided phones with explanations done with management. Verified reports are done a half hour after each shift begins.

Based on verification of the facilities immediacy removal action plan, education, review of physical changes in the telemetry room, and monitoring of

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A 000	Continued From page 2 nursing staff able to receive telemetry notification on at 6:06 PM resulted in the Immediate Jeopardy being removed.	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on facility policy, medical record review, observation, and interviews it was determined the facility failed to provide safe setting for patients on continuous telemetry monitoring in one (Patient #1) of one hundred and fifty-one patients on telemetry monitors on and three [(CVICU), 5 North ( ), 5 South Medical] hospital Units of 11 units with patients on monitoring. Refer to A0144.	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on facility policy, medial record review, observation and interviews it was determined that the facility failed to ensure patients received continuous telemetry monitoring in a safe setting in one (Patient #1) of one hundred and fifty-one patients on telemetry monitors and in 3 [(CVICU), 5 North ( ), 5 South Medical] hospital units of 11 units	A 144		

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A 144	Continued From page 3 being monitored. Findings included: Review of the facility Policy and Procedure titled, " Telemetry Monitoring", #WFD.PC.023, Revised ...Patient being monitored on continuous telemetry will be observed by a telemetry technician or nurse ... who is competent in rhythm interpretation & , detection ... changes in life-threatening , or , , ... suspected life threatening rhythm is detected the ...telemetry technician will immediately initiate the following process- activate a code blue response to the patient's bedside, notify the primary RN [Registered Nurse] or charge RN[CNC], document on the facility approved process for recording telemetry event notifications, print copy of disclosure with interpretation and send to unit ...non-lethal , is detected ...the monitor tech will call the primary nurse,, if no contact made or no response immediately escalate to the CNC. Within 2 minutes a nurse should assess the patient and contact the monitor technician and give an update on patient status and/or assure the patient' rhythm is being transmitted ... Second notification: if not resolution from a nurse within 2 minutes from time of initial notification, the monitor tech should call the units CNC and enter the notification time in log. The CNC should assess the patient status or assure the patient status is assessed and contact the monitor technician and given ... Third notification if no response within 4 minutes from time of initial notification, the monitor technician should initiate a Telemetry Alert ...overhead broadcasting should be used as a last resort ...At no time during the	A 144		

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A 144	Continued From page 4	A 144		

monitoring phase should alarms be turned off or silenced.
Review of Patient #1 medical record reveals:
1. On at 18:01 PM the telemetry strips showed / ( ) paced rhythm with ST elevation (2 points recognized in a heartbeat that when elevated can indicate , or also known as a).
2. On at 6:18 PM the telemetry strips showed an agonal rhythm (abnormally slow rhythm that occurs at the end of life. It should be regarded as , (no electrical activity of the) and should be treated with , , .)
3. The telemetry strips reviewed for Patient #1 from at 6:01 PM through at 6:42 PM reveals the alarms were off on 13 telemetry strips and silenced on 6 telemetry strips out of 23 telemetry strips reviewed for Patient #1. This indicates that the audible alarms notifying the telemetry technician of an abnormality in the rhythm were silenced or turned off.

Review of facility documents reveals that there is no evidence of the telemetry log being completed on from 6:00 AM through 6:30 PM for 3rd floor medical surgical unit, in which Patient #1 was present. A log was started at 6:30PM with the oncoming shift and, the telemetry log reveals that on 6:32 PM the telemetry tech attempted to notify nursing Staff M with no answer by the RN. The telemetry tech attempted to call the nursing station at 6:32 PM with no answer. On 6:33 PM the telemetry tech had done an overhead broadcast to check Patient #1. At 6:36 PM the telemetry tech did an overhead page again. At

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A 144	Continued From page 5 6:40 PM a rapid response was called to Patient #1's room and at 6:47 PM a code blue called to Patient #1's room. Patient #1 expired at 6:54 PM. Facility documents revealed staff O, who was monitoring Patient #1's telemetry from 6:45 AM to 6:30PM, had no current competency for basic . Interview on at 10:20 AM with staff B reveals that Staff member O has been removed from the telemetry monitoring position. Staff B interview on at 12:00 PM revealed the telemetry does not alarm for ST changes or ST elevation (2 points recognized in a heartbeat that when elevated can indicate or also known as a .) Observation on at 12:35 PM reveals there were 3 telemetry monitor technicians in the telemetry monitoring room. There were 3 stations of telemetry monitors with 3 monitor screens on the right and left with the middle station having 4 screens. Staff F on the middle screens left the room and returned approximately 2 minutes later. Observed 3 monitor screens with on the wall with no technician monitoring them nor any chair in front of them. (Photo evidence obtained.) On at 12:50 PM an interview with Staff B confirms no one was watching the ( ) monitors. Staff B stated if the alarms go off the nurse in will answer it at bedside.	A 144		

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A 144	Continued From page 6 On at 1:35 PM an interview with Staff I confirms no telemetry tech is assigned to watch monitors. On at 12:00 PM an interview with Staff B confirms that there is no person watching the telemetry monitors in 's. Staff B disclosed 's have a charge nurse who sits at the desk, but she has extra duties and will leave the nursing station to provide care.	A 144		
A 263	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 , , 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 facility documents, Quality and Patient Safety Plan, and interviews the facility failed to ensure that clear expectations for patient safety were implemented by a Quality Assurance Performance Improvement (QAPI) program unique	A 263		

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A 263	Continued From page 7 to the hospital . The QAPI system failed to react to adverse incidents and failed to develop and implement measures to prevent further occurrences after multiple systemic process failures that resulted in deaths of patients related to telemetry recognition and nursing notification of lethal rhythms. Refer to A0321. The condition is not met due to the systemic failure to maintain a functioning QAPI system to investigate, track and trend, and implement measures to prevent harm to patients in their facility based on adverse events.	A 263		
A 321	SYSTEM QAPI HOSPITAL CIRCUMSTANCES CFR(s): 482.21(f)(1) The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and This STANDARD is not met as evidenced by: Based on facility document, Quality and Patient Safety Plan, and interviews the facility failed to implement an effective Quality Assessment and Performance Improvement (QAPI) program unique to the hospital to prevent multiple systemic process failures in one of one QAPI program. Findings included: Review of the facility QAPI program reveals the program in place does not take into account the unique circumstances of services offered to focus on improved health outcomes related to continuous telemetry monitoring.	A 321		

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A 321	Continued From page 8 Review of the 2022 Quality & Patient Safety Plan ...the quality improvement plan (QI) provides an organization-wide systemic approach to plan, measure, evaluate and improve clinical outcomes and operational performance ...signed on by the Chief Executive Officer (CEO), the Chief Medical Officer (CMO), the Vice President (VP) of Quality, and the Chairman Board of Trustees. On at 3:00 PM Interview with the Director of Quality reveals the facility had failed to trend and analyze the reported incidents from 3 deaths in the last 12 months related to telemetry monitoring for patient care, patient safety, notifications, and outcomes.	A 321		
A 385	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 observation, medical record reviews, facility policy review, and interviews it was determined the facility failed to provide: A. Immediate nursing care for a patient with a change in . . . . . rhythm on telemetry monitoring resulting in the patient's . . . . . Refer to A0392 B. Qualified nursing personnel for telemetry monitoring. Refer to A0397.	A 385		

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A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient. This STANDARD is not met as evidenced by: Based on facility policy, medical record review, facility documents, observation and interviews it was determined the facility failed to provide immediate care for a patient on monitoring that had a change in rhythm in one (Patient#1) out of one hundred and fifty-one on telemetry being monitored on . Findings included: Review of the facility Policy and Procedure title, " Telemetry Monitoring", # WFD.PC.023, Revised ...Rhythm changes is detected ...the monitor tech will call the primary nurse, if no contact made or no response immediately escalate to the Clinical Nurse Coordinator (CNC). Within 2 minutes a nurse should assess the patient and contact the monitor technician and give an update on patient status and/or assure the patient' rhythm is being transmitted ...Second notification: if not resolution from a nurse within 2 minutes from time of initial notification, the monitor tech should call the units CNC and enter the notification time in log ... Third notification if no response within 4 minutes from	A 392		

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time of initial notification, the monitor technician should initiate a Telemetry Alert ...overhead broadcasting should be used as a last resort ...At no time during the monitoring phase should alarms be turned off or silenced.

A.
Review of Patient #1 medical record that on at 6:33 PM a telemetry alert sent via hospital provided phone and at 6:41 PM a rapid response was called to patient #1 room. On at 6:42 PM a code blue was initiated. Patient #1 expired at 6:54 PM.

Review of the facility documents revealed that staff M failed to complete a nursing assessment of Patient #1 during the 7am -7pm (12-hour shift). On at 5:30 PM the Patient Care Technician (PCT) informed staff M that Patient #1 was and the PCT applied on Patient #1. Staff M failed to reassess the patient. Further review of the facility documents reveals that the facility provided phone was not answered when the telemetry technician called for notification of status change in Patient #1 condition.

B.
The telemetry strips reviewed for Patient #1 from at 6:01 PM through at 6:42 PM reveals the alarms were turned off on 13 telemetry strips and silenced on 6 telemetry strips out of 23 telemetry strips reviewed for Patient #1.

Review of Patient #1 Telemetry notification log reveals that there is no evidence of log being

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completed on from 6:00 AM through 6:30 PM. Patient #1 telemetry log reveals that on 6:32 PM the telemetry technician attempted to notify Staff M with no answer by the RN. The telemetry technician attempted to call the nursing station at 6:32 PM with no answer. On 6:33 PM the monitor tech had done an overhead broadcast to check the tele patient #1. At 6:36 PM the monitor tech did an overhead page again. At 6:40 PM a rapid response was called to Patient #1 room and at 6:47 PM a code blue called to Patient #1 room.

Observation on at 12:35 PM reveals there were 3 telemetry monitors technicians in the telemetry monitoring room. There were 3 stations of telemetry monitors with 3 monitor screens on the right and left with the middle station having 4 screens. Staff F on the middle screens left the room and returned approximately 2 minutes later. Observed 3 monitor screens on the wall with no technician monitoring them nor any chair in front of them. (Photo evidence obtained)

On at 12:50 PM an interview with Staff B confirms no one was watching the ( ) monitors along the wall. Staff B stated if the alarms go off the nurse in will answer it at bedside.

On at 1:35 PM an interview with Staff I confirms no telemetry tech is assigned to watch monitors.

On at 12:00 PM an interview with Staff B confirms that there is no person watching the telemetry monitors in . Staff B disclosed

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A 392	Continued From page 12 have a charge nurse who sits at the desk, but she has extra duties and will leave the nursing station to provide care. Staff B interview on at 12:00 PM revealed the telemetry does not alarm for ST changes ((2 points recognized in a heartbeat that when elevated can indicate , or also known as a .)	A 392		
A 397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on facility policy, medical record review, facility documents, and interviews the facility failed to have qualified staff to monitor the telemetry monitors. In one (staff O) out of four staff files reviewed. Findings included: Review of the facility policy and procedure title, "Telemetry Monitoring", # WFD.PC.023, Revised ...Monitor Technician responsibilities a. patient will be monitored by a Monitor Technician or someone with equivalent competencies of basic ... Facility documents revealed no evidence that staff O is competent in rhythm interpretation & detection.	A 397		

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A 397	Continued From page 13 Interview on at 10:20 AM with staff B reveals that Staff member O has been removed from the telemetry monitoring position.	A 397		

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A 000	INITIAL COMMENTS A complaint survey for complaint # 2022012553 was conducted on through at HCA Florida Blake Hospital. The facility was not in compliance with CFR 482.13, CFR 482.21, and CFR 482.23. An Immediate Jeopardy (IJ) was identified beginning on at 12:45 PM. The Vice President of Quality and Patient Safety was notified of Immediate Jeopardy on at 4:00PM. The facility failed to recognize a change in rhythm and escalate process of notification resulting in a patient . Refer to Tag A144 The facility failed to provide immediate nursing care for a patient with a change in rhythm on telemetry monitoring resulting in the patient's . Refer to tag A0392. The facility failed to provide qualified nursing personnel for telemetry monitoring. Refer to tag A0397. These placed the patients on telemetry monitoring at risk of injury or due to unidentified , and resulted in the Condition of Participation being out of compliance. The effect of these systemic failures resulted in the identification of Immediate Jeopardy for those patients on telemetry. An Immediate Jeopardy action removal plan provided by the facility on which	A 000		

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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 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.

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included:

All telemetry staff are required to review the telemetry monitoring process regarding audible alarms and be validated on current shift and prior to any oncoming staff working their shift. Completed with staff onsite and observed by surveyors. Education for additional staff prior to working is ongoing. Review of documentation and attestation of staff was completed.

telemetry monitoring was moved to central telemetry visible to telemetry technicians, completed . Observation of telemetry monitoring room was done, monitors moved to areas where staff are currently monitoring other units. Observation of patients with alarms not silenced completed.

Alarms turned on for ST elevation on telemetry monitoring and staff oriented to change. Alarm change completed onsite . Education ongoing. Verification with telemetry staff completed.

Tracking of staff signing into the hospital provided phones to receive telemetry alerts. Reports verified by surveyor. Monitoring ongoing. Review of current staff not signed into hospital provided phones with explanations done with management. Verified reports are done a half hour after each shift begins.

Based on verification of the facilities immediacy removal action plan, education, review of physical changes in the telemetry room, and monitoring of nursing staff able to receive telemetry notification on at 6:06 PM resulted in the Immediate Jeopardy being removed.

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A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on facility policy, medical record review, observation, and interviews it was determined the facility failed to provide safe setting for patients on continuous telemetry monitoring in one (Patient #1) of one hundred and fifty-one patients on telemetry monitors on and three [(CVICU), 5 North ( ), 5 South Medical] hospital Units of 11 units with patients on monitoring. Refer to A0144.	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on facility policy, medial record review, observation and interviews it was determined that the facility failed to ensure patients received continuous telemetry monitoring in a safe setting in one (Patient #1) of one hundred and fifty-one patients on telemetry monitors and in 3 [(CVICU), 5 North ( ), 5 South Medical] hospital units of 11 units being monitored. Findings included: Review of the facility Policy and Procedure titled, " Telemetry Monitoring", #WFD.PC.023, Revised ...Patient being monitored on	A 144		

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A 144	Continued From page 3 continuous telemetry will be observed by a telemetry technician or nurse ... who is competent in . . . . . rhythm interpretation & . . . detection ... changes in life-threatening . . . . . or . . . . suspected life threatening rhythm is detected the ...telemetry technician will immediately initiate the following process- activate a code blue response to the patient's bedside, notify the primary RN [Registered Nurse] or charge RN[CNC], document on the facility approved process for recording telemetry event notifications, print copy of disclosure with interpretation and send to unit ...non-lethal . . . . . is detected ...the monitor tech will call the primary nurse,, if no contact made or no response immediately escalate to the CNC. Within 2 minutes a nurse should assess the patient and contact the monitor technician and give an update on patient status and/or assure the patient' rhythm is being transmitted ... Second notification: if not resolution from a nurse within 2 minutes from time of initial notification, the monitor tech should call the units CNC and enter the notification time in log. The CNC should assess the patient status or assure the patient status is assessed and contact the monitor technician and given ... Third notification if no response within 4 minutes from time of initial notification, the monitor technician should initiate a Telemetry Alert ...overhead broadcasting should be used as a last resort ...At no time during the monitoring phase should alarms be turned off or silenced. Review of Patient #1 medical record reveals: 1. On . . . . . at 18:01 PM the telemetry strips showed . . / . . (.) paced . . . . . rhythm with ST elevation (2 points recognized in a heartbeat that when elevated can indicate . . . . . or . . . . . also	A 144		

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A 144	Continued From page 4 known as a). 2. On at 6:18 PM the telemetry strips showed an agonal rhythm (abnormally slow rhythm that occurs at the end of life. It should be regarded as (no electrical activity of the) and should be treated with .) 3. The telemetry strips reviewed for Patient #1 from at 6:01 PM through at 6:42 PM reveals the alarms were off on 13 telemetry strips and silenced on 6 telemetry strips out of 23 telemetry strips reviewed for Patient #1. This indicates that the audible alarms notifying the telemetry technician of an abnormality in the rhythm were silenced or turned off. Review of facility documents reveals that there is no evidence of the telemetry log being completed on from 6:00 AM through 6:30 PM for 3rd floor medical surgical unit, in which Patient #1 was present. A log was started at 6:30PM with the oncoming shift and, the telemetry log reveals that on 6:32 PM the telemetry tech attempted to notify nursing Staff M with no answer by the RN. The telemetry tech attempted to call the nursing station at 6:32 PM with no answer. On 6:33 PM the telemetry tech had done an overhead broadcast to check Patient #1. At 6:36 PM the telemetry tech did an overhead page again. At 6:40 PM a rapid response was called to Patient #1's room and at 6:47 PM a code blue called to Patient #1's room. Patient #1 expired at 6:54 PM. Facility documents revealed staff O, who was monitoring Patient #1's telemetry from 6:45 AM to 6:30PM, had no current competency for basic . Interview on at 10:20 AM with staff B	A 144		

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A 144	Continued From page 5	A 144		

reveals that Staff member O has been removed from the telemetry monitoring position.

Staff B interview on at 12:00 PM revealed the telemetry does not alarm for ST changes or ST elevation (2 points recognized in a heartbeat that when elevated can indicate or also known as a .)

Observation on at 12:35 PM reveals there were 3 telemetry monitor technicians in the telemetry monitoring room. There were 3 stations of telemetry monitors with 3 monitor screens on the right and left with the middle station having 4 screens. Staff F on the middle screens left the room and returned approximately 2 minutes later. Observed 3 monitor screens with on the wall with no technician monitoring them nor any chair in front of them. (Photo evidence obtained.)

On at 12:50 PM an interview with Staff B confirms no one was watching the ( ) monitors. Staff B stated if the alarms go off the nurse in will answer it at bedside.

On at 1:35 PM an interview with Staff I confirms no telemetry tech is assigned to watch monitors.

On at 12:00 PM an interview with Staff B confirms that there is no person watching the telemetry monitors in 's. Staff B disclosed 's have a charge nurse who sits at the desk, but she has extra duties and will leave the nursing station to provide care.

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A 263	Continued From page 6	A 263		
A 263	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 , , 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 facility documents, Quality and Patient Safety Plan, and interviews the facility failed to ensure that clear expectations for patient safety were implemented by a Quality Assurance Performance Improvement (QAPI) program unique to the hospital . The QAPI system failed to react to adverse incidents and failed to develop and implement measures to prevent further occurrences after multiple systemic process failures that resulted in deaths of patients related to telemetry recognition and nursing notification of lethal rhythms. Refer to A0321. The condition is not met due to the systemic failure to maintain a functioning QAPI system to investigate, track and trend, and implement measures to prevent harm to patients in their	A 263		

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A 263	Continued From page 7 facility based on adverse events.	A 263		
A 321	SYSTEM QAPI HOSPITAL CIRCUMSTANCES CFR(s): 482.21(f)(1) The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and This STANDARD is not met as evidenced by: Based on facility document, Quality and Patient Safety Plan, and interviews the facility failed to implement an effective Quality Assessment and Performance Improvement (QAPI) program unique to the hospital to prevent multiple systemic process failures in one of one QAPI program. Findings included: Review of the facility QAPI program reveals the program in place does not take into account the unique circumstances of services offered to focus on improved health outcomes related to continuous telemetry monitoring. Review of the 2022 Quality & Patient Safety Plan ...the quality improvement plan (QI) provides an organization-wide systemic approach to plan, measure, evaluate and improve clinical outcomes and operational performance ...signed on by the Chief Executive Officer (CEO), the Chief Medical Officer (CMO), the Vice President (VP) of Quality, and the Chairman Board of Trustees. On . . . . . at 3:00 PM Interview with the	A 321		

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A 321	Continued From page 8 Director of Quality reveals the facility had failed to trend and analyze the reported incidents from 3 deaths in the last 12 months related to . . . . telemetry monitoring for patient care, patient safety, notifications, and outcomes.	A 321		
A 385	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 observation, medical record reviews, facility policy review, and interviews it was determined the facility failed to provide: A. Immediate nursing care for a patient with a change in . . . . rhythm on telemetry monitoring resulting in the patient's . Refer to A0392 B. Qualified nursing personnel for telemetry monitoring. Refer to A0397.	A 385		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient. This STANDARD is not met as evidenced by: Based on facility policy, medical record review,	A 392		

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A 392	Continued From page 9 facility documents, observation and interviews it was determined the facility failed to provide immediate care for a patient on . . . . . monitoring that had a change in rhythm in one (Patient#1) out of one hundred and fifty-one on telemetry being monitored on . . . . . . Findings included: Review of the facility Policy and Procedure title, " Telemetry Monitoring", # WFD.PC.023, Revised . . . .Rhythm changes is detected ...the monitor tech will call the primary nurse, if no contact made or no response immediately escalate to the Clinical Nurse Coordinator (CNC). Within 2 minutes a nurse should assess the patient and contact the monitor technician and give an update on patient status and/or assure the patient' rhythm is being transmitted ...Second notification: if not resolution from a nurse within 2 minutes from time of initial notification, the monitor tech should call the units CNC and enter the notification time in log ... Third notification if no response within 4 minutes from time of initial notification, the monitor technician should initiate a Telemetry Alert ...overhead broadcasting should be used as a last resort ...At no time during the monitoring phase should alarms be turned off or silenced. A. Review of Patient #1 medical record that on at 6:33 PM a telemetry alert sent via hospital provided phone and at 6:41 PM a rapid response was called to patient #1 room. On . . . . . at 6:42 PM a code blue was initiated. Patient #1 expired at 6:54 PM.	A 392		

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Review of the facility documents revealed that staff M failed to complete a nursing assessment of Patient #1 during the ..... 7am -7pm (12-hour shift). On at 5:30 PM the Patient Care Technician (PCT) informed staff M that Patient #1 was and the PCT applied ..... on Patient #1. Staff M failed to reassess the patient. Further review of the facility documents reveals that the facility provided phone was not answered when the telemetry technician called for notification of status change in Patient #1 condition.

B.
The ..... telemetry strips reviewed for Patient #1 from at 6:01 PM through ..... at 6:42 PM reveals the alarms were turned off on 13 telemetry strips and silenced on 6 telemetry strips out of 23 telemetry strips reviewed for Patient #1.

Review of Patient #1 Telemetry notification log reveals that there is no evidence of log being completed on from 6:00 AM through 6:30 PM. Patient #1 telemetry log reveals that on 6:32 PM the telemetry technician attempted to notify Staff M with no answer by the RN. The telemetry technician attempted to call the nursing station at 6:32 PM with no answer. On 6:33 PM the monitor tech had done an overhead broadcast to check the tele patient #1. At 6:36 PM the monitor tech did an overhead page again. At 6:40 PM a rapid response was called to Patient #1 room and at 6:47 PM a code blue called to Patient #1 room.

Observation on ..... at 12:35 PM reveals there were 3 telemetry monitors technicians in the telemetry monitoring room. There were 3 stations

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A 392	Continued From page 11 of telemetry monitors with 3 monitor screens on the right and left with the middle station having 4 screens. Staff F on the middle screens left the room and returned approximately 2 minutes later. Observed 3 monitor screens on the wall with no technician monitoring them nor any chair in front of them. (Photo evidence obtained) On at 12:50 PM an interview with Staff B confirms no one was watching the ( ) monitors along the wall. Staff B stated if the alarms go off the nurse in will answer it at bedside. On at 1:35 PM an interview with Staff I confirms no telemetry tech is assigned to watch monitors. On at 12:00 PM an interview with Staff B confirms that there is no person watching the telemetry monitors in . Staff B disclosed have a charge nurse who sits at the desk, but she has extra duties and will leave the nursing station to provide care. Staff B interview on at 12:00 PM revealed the telemetry does not alarm for ST changes ((2 points recognized in a heartbeat that when elevated can indicate , or also known as a .)	A 392		
A 397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.	A 397		

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A 397	Continued From page 12 This STANDARD is not met as evidenced by: Based on facility policy, medical record review, facility documents, and interviews the facility failed to have qualified staff to monitor the telemetry monitors. In one (staff O) out of four staff files reviewed. Findings included: Review of the facility policy and procedure title, "Telemetry Monitoring", # WFD.PC.023, Revised ...Monitor Technician responsibilities a. patient will be monitored by a Monitor Technician or someone with equivalent competencies of basic ... Facility documents revealed no evidence that staff O is competent in rhythm interpretation & detection. Interview on at 10:20 AM with staff B reveals that Staff member O has been removed from the telemetry monitoring position.	A 397		