

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL5579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
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NAME OF PROVIDER OR SUPPLIER PREMIER RADIOLOGY BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 789 OLD HICKORY BLVD BRENTWOOD, TN 37027
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G 001	1200-8-35 Initial This Rule is not met as evidenced by: An unannounced complaint investigation #C000370-081225 was initiated on 9/3/2025. An entrance conference was held with the Lead Patient Service Representative at 9:25 AM. A second onsite visit was conducted on 9/16.2025 to conduct interviews with facility Counsel present, per the facility request. A telephone exit conference was held on 10/2/2025 at 1:00 PM with the ODC Counsel.	G 001		
G 401	1200-8-35-.04(1) Administration. (1) The Outpatient Diagnostic Center must have an effective governing body legally responsible for the conduct of the Outpatient Diagnostic Center. If an Outpatient Diagnostic Center does not have an organized governing body, the persons legally responsible for the conduct of the Outpatient Diagnostic Center must carry out the functions specified in this chapter. This ELEMENT is not met as evidenced by: Based on policy review, document review, medical record review, audio review of the 911 call, and interview, the Governing Body failed to develop written guidelines for staff to determine when a patient was not medically stable for imaging procedures, failed to ensure staff were adequately trained on the use of emergency medical equipment, and failed to ensure emergency equipment (Automated External Defibrillator (AED) was maintained in proper working order to ensure staff responded timely and effectively to emergencies for 1 of 3 (Patient #2) patients who presented to the facility for a	G 401		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Davis TITLE: Director of Radiology (X6) DATE: 10/31/25

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G 401	<p>Continued From page 1</p> <p>Magnetic Resonance Imaging (MRI) and became non-responsive during the MRI procedure. Patient #2 [REDACTED] at Hospital #1.</p> <p>The findings included:</p> <p>1. Review of the facility policy "Emergency Crash Cart" with <u>no effective date revealed</u> "...The AED defibrillator (is a portable electronic device that analyzes the heart's rhythm and delivers an electric shock to a person experiencing sudden cardiac arrest to help restore a normal heartbeat) must be plugged into the electrical outlet at all times when not in use in order to recharge the batteries...A center staff member will be responsible for checking the crash cart and completing the daily checklist which includes, at a minimum...testing the AED..."</p> <p>Review of the facility's MRI Quality Assurance (QA) Procedure manual under the section titled, Procedure for Response to a Respiratory/Cardiac Arrest in the Magnet Room, with no effective date revealed, "Policy: It is the policy of [named ODC] to respond promptly and appropriately in the event of a respiratory or cardiac arrest of a patient during an MRI. Procedure: 1. In the event of a respiratory or cardiac arrest of a patient during an MRI...The technologist shall immediately contact Emergency Medical Services. 2. Any center personnel in the immediate area shall be requested to provide assistance, and the magnet room shall be closed to prevent anyone from entering the MRI room without proper screening for contraindication to MRI or possession to loose magnetic objects. 3. The patient shall be transferred to the non-magnetic patient stretcher or removed from the MRI scan room by using the MRI system's</p>	G 401	<p>Continued From page 1</p> <p>Reference 1200-8-35-.04 (1) Administration</p> <p>1. Policies will be updated to reflect effective date as well as a reviewed date. Template attached as Attachment A. To keep this deficiency from recurring, MRI specific policies will be reviewed on an annual basis by the Governing Body. In addition to this, if a policy is updated at any time during review it will be shared with all appropriate staff via email.</p>	11/1/25

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G 401	<p>Continued From page 3</p> <p>Record review revealed Patient #2 presented to the Outpatient Diagnostic Center (ODC) on [REDACTED] for a MRI of his [REDACTED] for a diagnosis of [REDACTED].</p> <p>Patient #2 completed the MRI patient information and screening tool on [REDACTED] prior to his procedure, and indicated he had a Pacemaker and implanted cardiac defibrillator.</p> <p>Review of the Cardiac Device Monitoring Sheet for Patient #2 dated [REDACTED] revealed at 1:30 PM Patient #2's Blood pressure (BP) was [REDACTED] and his Oxygen (O2) saturation (sat) (O2 sat measures percent of oxygen in the blood, normal 95 - 100) was [REDACTED]%. In addition, the following O2 sats were recorded while Patient #2 was in the MRI scan:</p> <p>At 1:40 PM- O2 Sat- [REDACTED]%, At 1:45 PM- O2 Sat- [REDACTED]%, At 1:50 PM - O2 Sat- [REDACTED]%, At 1:58 PM- O2 Sat- [REDACTED]%, At 2:00 PM- O2 Sat- [REDACTED]%. </p> <p>Review of an online article by Harvard Health revealed Oxygen saturation levels in the blood indicate the amount of oxygen in the blood with normal levels ranging from 95% to 100%. Oxygen saturation refers to the percentage of hemoglobin in the blood saturated with oxygen. It is a crucial measure of how well oxygen is being transported from the lungs to the rest of the body. Low levels are below 92% and may indicate hypoxemia, which can lead to shortness of breath, confusion and chest pain, with immediate attention needed if levels drop significantly. Dangerous low levels are below 80-85% and can severely affect brain function.</p>	G 401	<p>Continued From page 3</p> <p>3. The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse and certified in ACLS and BLS on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p> <p>On 8/20/25, an upgraded MRI safe patient monitor was ordered. This was delivered on 10/8/25. Training for staff on this monitor occurred on 10/8/25 by the on-site nurse who is a State of TN licensed registered nurse. Any additional or new staff will also be trained by the on-site nurse. See attached training documentation (Attachment F). An MRI-safe vital signs monitor is a specially designed medical device used to continuously measure and display a patient's vital signs such as heart rate, blood pressure, oxygen saturation (SPO2), respiration rate-while the patient is inside or near an MRI scanner.</p>	<p>10/31/25</p> <p>10/8/25</p>

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G 401	<p>Continued From page 4</p> <p>Review of an online article by Circulation, revealed Hypoxemia is indicated if Oxygen saturation drops below 90%.</p> <p>ODC staff documented, "Placed pt [patient] out of surescan [implanted cardiac defibrillator device taken out of MRI DOO safe mode] after stretched! [Patient was placed on a stretcher]" There was <u>no staff signature on the Cardiac Device Monitoring Sheet to determine who completed the documentation.</u></p> <p>The Assistant Vice President (AVP) downloaded the data information from the MRI SureScan and provided the report to the surveyor. The AVP stated this data would have to be interpreted by (Named Company) and she did not know what the data meant. Please refer to the interview below with the (Named Company) Manager who interpreted the data as showing Patient #2's implanted defibrillator device was not turned on to surescan DOO mode on [REDACTED] until 2:39 PM (37 minutes after the 911 call was made to report Patient #2 was unresponsive).</p> <p>4. Review of the ODC Patient Incident Report for Patient #2 dated [REDACTED] and completed by MRI Technician (Tech) #1 revealed an incident occurred while Patient #2 was in the MRI scan on [REDACTED] and the incident was witnessed by MRI Tech #1, MRI Tech #2, the Lead Patient Service Representative (PSR) and a Computed (CT) Tomography Tech.</p> <p>Review of the handwritten statement by MRI Tech #1 revealed the following: "Pt [Patient #2] brought into scan room 1:35 PM.</p>	G 401	<p>Continued From page 4</p> <p>3. The Cardiac Device Monitoring Sheet has been updated to reflect the employee's signature that performed the documentation. The sheet will be used to document vitals and when the device was placed in and out of safe mode. See Attachment C. All appropriate staff were notified of this change. To keep this deficiency from recurring, the on-site RN will monitor on a monthly basis by reviewing scanned in documents for all completed exams. In addition to this, the technologist will perform real-time monitoring by documenting when the device is placed in and out of safe mode by completing the Cardiac Device Monitoring Sheet prior to the exam, during the exam, and after the exam. This sheet will also be verified and signed off on by the second technologist or on-site RN to "double check" the device is placed in safe mode and back into normal mode. The Cardiac Device Monitoring Sheet has been updated to reflect this change, and staff were notified via email on 10/31/25. Any additional or new staff will also be trained in this process.</p>	10/31/25

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G 401	<p>Continued From page 5</p> <p>When [named MRI Tech #2] placed him [Patient #2] on [MRI] table he [Patient #2] expressed difficulty breathing. He was then put on O2- 2 [liters refers to a flow rate of [redacted] liters per minute of supplemental oxygen]. He [Patient #2] asked if we would delay scanning while he caught his breath. We did and [MRI Tech #2] increased [O2] to [redacted] liters. Started Scan- 1:40 PM, finger monitor place [placed on Patient #2's finger] with O2 reading [redacted]. Due to monitor frequently coming off [finger] visually in person checked on pt. He was having an [redacted] so his head was not in scanner. Repeated pauses in scanning to verbally check on pt. He [Patient #2] indicated he wanted his head propped up higher and nodded that he was ok. I told him we were more than 1/2 [half] way done. Less than 3 minutes before end of the last [scanning] sequence I went in and he nodded. Finished exam [MRI] and pt was unresponsive. Grabbed [named MRI Tech #2] to assist. Asked [named Lead PSR] to call code [code means emergency resuscitative measures are needed]."</p> <p>Review of MRI Tech #1's Post Scanning timeline notes for Patient #2 revealed: "pt unresponsive, grabbed MRI Tech #2 to assist, Asked Lead PSR to call 911, MRI Tech #2 and CT Tech and me slid pt to stretcher, removed out of MRI room, I placed pt's defib back in normal mode using programmer, Pt wheeled to an transferred to CT table, CPR begun [by MRI Tech #2], Pts internal defib began shocking pt, EMS [Emergency Services Personnel] arrived."</p> <p>Review of the 911 audio recording initiated by the Lead PSR on [redacted] at 2:02 PM (9 minutes in length) revealed the following: 00:18 (seconds)- Lead PSR can be heard stating she had an emergency and provided the address.</p>	G 401	<p>Reference 1200-8-35-.04 (1) Administration</p> <p>Continued From page 5</p> <p>4. The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/ procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse and certified in ACLS and BLS on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p> <p>On 8/20/25, an upgraded MRI safe patient monitor was ordered. This was delivered on 10/8/25. Training for staff on this monitor occurred on 10/8/25 by the on-site nurse who is a State of TN licensed registered nurse. Any additional or new staff will also be trained by the on-site nurse. See attached training documentation (Attachment F). An MRI-safe vital signs monitor is a specially designed medical device used to continuously measure and display a patient's vital signs such as heart rate, blood pressure, oxygen saturation (SPO2), respiration rate-while the patient is inside or near an MRI scanner.</p>	<p>10/31/25</p> <p>10/8/25</p>

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G 401	<p>Continued From page 6</p> <p>00:30- The 911 Operator located the address, described the street crossing and asked, "Is this [named ODC]?"</p> <p>00:56- Lead PSR provided 911 operator with her first and last name.</p> <p>1:03- 911 Operator asked what the emergency was.</p> <p>1:05- Lead PSR can be heard ask MRI Tech #1 "What's going on?"</p> <p>1:10- Lead PSR stated she was walking back into the treatment/imaging area- Lead PSR can be heard moving.</p> <p>1:18- Lead PSR stated to 911 Operator there was a patient (Patient #2) on the MRI table not responding.</p> <p>1:22- The 911 Operator asked if the patient was conscious.</p> <p>1:23- The Lead PSR responded "No."</p> <p>1:26- The Lead PSR can be heard asking unknown staff "Did you say he's blue?" The Lead PSR then stated to the 911 Operator "He's turning blue."</p> <p>1:38- Lead PSR stated the patient did not have a pulse.</p> <p>1:48- The 911 Operator asked, "Can you get the phone next to the patient?"</p> <p>1:49- Lead PSR stated, "He's on the MRI table ..I can't get to the patient..."</p> <p>1:58- Lead PSR informed the 911 Operator the staff was transferring Patient #2 to a stretcher. The Lead PSR can be heard asking staff "Are y'all gonna do CPR (Cardiopulmonary resuscitation)?"</p> <p>2:05- Lead PSR stated "They are about to do CPR they are putting him on a stretcher to do CPR."</p> <p>2:14- The 911 Operator asked the patient's age.</p> <p>2:39- Lead PSR told the 911 Operator the patient was [REDACTED]. The Lead PSR could be heard saying the patient's first name while reading his medical information.</p>	G 401	Reference 1200-8-35-.04 (1) Administration Continued From page 6	

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G 401	<p>Continued From page 7</p> <p>3:17- The 911 Operator again verified the ODC address and stated an EMS unit was in route.</p> <p>3:24- The 911 Operator asked if there was an AED available. Lead PCR stated "Yes"</p> <p>3:28- The 911 Operator asked, "Can you go ahead and grab it [AED]?"</p> <p>3:32- Lead PSR can be heard moving and stated she was running down the hall.</p> <p>3:58- Lead PSR stated "He [unknown staff] has it [AED]."</p> <p>4:11- The Lead PSR again stated they had the AED.</p> <p>4:15- The 911 Operator instructed/explained to position the AED close to the patient left ear, on a dry nonmetallic surface free from any hazardous material.</p> <p>4:23- Lead PSR can be heard repeating these instructions to the ODC staff with AED, and 911 Operator repeated the same instructions.</p> <p>4:30- Lead PSR can be heard instructing staff to put AED close to his [Patient #2's] left ear.</p> <p>4:42- The 911 Operator stated the patient must be on his back.</p> <p>4:45- Lead PSR stated "He is on his back."</p> <p>4:46- The 911 Operator instructed to turn the AED on and gave some instructions on use</p> <p>4:56- The 911 Operator instructed the PSR to lift up the patient's shirt and access the patient's bare chest.</p> <p>5:18- The 911 Operator instructed the AED pads must be placed 3-5 inches away from Patient #2's pacemaker.</p> <p>5:21- Lead PSR can be heard repeating this to staff.</p> <p>5:28- The 911 Operator asked if the AED pads were plugged into the machine.</p> <p>5:31- The Lead PSR can be heard repeating this question to staff.</p> <p>5:34- The 911 Operator stated, "If not, plug them in now."</p>	G 401	<p>Continue From page 7</p> <p>4. On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p> <p>In addition to these items, a code blue drill has been implemented to be performed on a quarterly basis. The AED was used during the drill for additional training. The first drill was performed on 9/24/25 by the site manager who is a licensed registered technologist and the on-site nurse who is a State of TN licensed registered nurse. Both are also ACLS and BLS certified. See Attachment D.</p>	<p>7/17/25</p> <p>9/24/25</p>

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G 401	<p>Continued From page 8</p> <p>5:39- The 911 Operator instructed to open and attach the self-adhesive pads directly to the skin of the patient.</p> <p>5:55- The Lead PSR stated the staff was getting the pads on the patient, then stated, "They need to plug it in again, sorry."</p> <p>6:05- The 911 Operator explained the AED might start to give audible instructions as well.</p> <p>6:13- Lead PSR stated the AED was plugged in.</p> <p>6:16- Lead PSR stated the plugged-in pads were attached.</p> <p>6:31- The 911 Operator stated make sure the pads are 3-5 inches away from his pacemaker.</p> <p>6:36- The 911 Operator stated one pad should be placed on the upper Right side of the chest, directly below the collarbone.</p> <p>6:40- The 911 Operator stated the other pad should be place on the patient's left chest with the top of the pad a few inches below the armpit.</p> <p>6:47- The Lead PSR can be heard asking staff how may pads they have left</p> <p>6:54- Lead PSR stated, "Yeah we don't have enough [pads] ...I'm sorry ..."</p> <p>7:04- Lead PSR stated, "Right now they are doing compressions on his chest."</p> <p>7:09- the 911 Operator replied "Okay."</p> <p>7:10 - the 911 Operator asked what was wrong with the pads.</p> <p>7:12- The Lead PSR can be heard asking staff "What's wrong with the pads guys, are they connected?"</p> <p>7:15 The Lead PSR stated, "We can't find the connection for it." The PSR stated she was going to ask someone else real quick.</p> <p>7:36- The 911 Operator asked " ...are you still there with me?"</p> <p>7:44- The Lead PSR stated they were doing CPR and were trying to get the pads plugged in The Lead PSR stated, "...I can't tell if they [pads] are on... the police is here."</p>	G 401		

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G 401	<p>Continued From page 9</p> <p>7:59- The 911 Operator asked again if the AED was plugged in. 8:07- The 911 Operator instructed to make sure before starting with the AED that everyone is clear from the patient. 8:13- The Lead PSR stated No the AED was not plugged in 8:17- The 911 operator asked, "You haven't plugged the pads in?" 8:22- The Lead PSR stated, "No we haven't plugged the pads in, we can't find the plug in for the pads..." 8:31- The Lead PSR stated Fire Safety had arrived. 8:35- The 911 Operator stated if the medics had arrived he would go ahead and end the call. 8:57- The Lead PSR stated the medics were in the room with the patient.</p> <p>5. Review of the EMS Prehospital Care Report dated [REDACTED] revealed the EMS unit was notified at 2:03 PM and was en route at 2:04 PM to the ODC. The EMS unit arrived on scene at the ODC at 2:09 PM and reached Patient #2 at 2:10 PM. Review of the EMS narrative documented by EMT/Paramedic #1 revealed, "...dispatched to cardiac or respiratory arrest. Upon arrival to scene, patient is laying on [REDACTED] machine table unresponsive, cyanotic, no breathing and no pulse. He is receiving some CPR and has nasal cannula and AED attached. <u>Staff reports AED does not work.</u> No PMH [past medical history] is obtained. CPR is taken over by [named EMS company]. Compressions are started and pads are placed on patient an monitor turned on. Airway is opened and BVM [big valve mask] with high flow oxygen is applied and manual respirations are started. Initial cardiac rhythm is pulseless v-fib, initial shock is delivered and high quality CPR is continued while patient is</p>	G 401	<p>Reference 1200-8-35-.04 (1) Administration</p> <p>Continued From page 9</p> <p>On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p>	7/17/25

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NAME OF PROVIDER OR SUPPLIER PREMIER RADIOLOGY BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 789 OLD HICKORY BLVD BRENTWOOD, TN 37027
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G 401	<p>Continued From page 10</p> <p>being prepared for transferred to cot and to ambulance..." Patient #2 was administered [REDACTED] with continued compressions but remained in pulseless electrical activity (PEA) - is a critical condition where the heart's electrical system functions normally, but the heart muscle does not contract effectively to produce a pulse; leads to cardiac arrest) a second dose of [REDACTED] was administered. Patient #2's care was transitioned to the Emergency Department (ED) staff at Hospital #1, while CPR continued on [REDACTED] at 2:30 PM.</p> <p>Review of Patient #2's History and Physical from Hospital #1 revealed, "...presents from outpatient MRI according to EMS after witnessed cardiac arrest...EMS states when they arrived there was bystander CPR. They checked and pt was in Vfib [ventricular fibrillation - a life-threatening cardiac arrhythmia where the heart's lower chambers quiver chaotically instead of beating normally, leading to a failure to pump blood to the body] got shocked one time, PEA after that...what I suspect happened is patient had a [REDACTED] while lying flat in MRI likely result of [REDACTED].Pt may have also had a cardiac event while his defibrillator was turned to pacemaker mode for the MRI..."</p> <p>Patient #2 was admitted to the hospital after being intubated and placed on mechanical ventilator. Patient #2 remained [REDACTED] with [REDACTED]. Patient #2 was made a do not resuscitate with comfort care by his wife after the hospital admission, was [REDACTED] and [REDACTED] soon after with family at his bedside. Patient #2 was [REDACTED] at 9:07 PM.</p>	G 401		

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G 401	<p>Continued From page 11</p> <p>6. During an interview on 9/3/2025 at 2:55 PM, the AVP stated the <u>facility did not have an exact time when CPR was initiated</u> for Patient #2, or a time when EMS arrived, so they did not include that information in their timeline of events with the root cause analysis.</p> <p>During an interview on 9/3/2025 at 3:25 PM, the AVP provided the survey team with the monthly AED checks for 2025. The AVP stated, "<u>We should have been checking it [the AED] daily</u> [per facility policy above], but we have never been cited that by the State [survey agency]".</p> <p>During an interview on 9/17/2025 at 10:44 AM, MRI Tech #1 stated Patient #2 presented to the ODC on [REDACTED] for an MRI of [REDACTED]. MRI Tech #2 stated his colleague, MRI Tech #2 retrieved Patient #2 from the waiting room, took the Patient's initial vital signs, and put the implanted device (pacemaker- defibrillator) in MRI safe mode. MRI Tech #1 stated they follow the manufacturer instructions, in this case the (Named Company) used an iPad to put the device in safe mode for the MRI procedure. MRI Tech #1 stated after the device was placed in safe mode the iPad prompts the tech to ask the patient if they feel comfortable. <u>MRI Tech #1 stated he did not observe MRI Tech #2 doing this, as he was at his console finishing with another patient.</u> MRI Tech #1 stated his first observation of Patient #2 was when MRI Tech #2 was walking the patient into the MRI area/room. MRI Tech #1 stated the patient had a walker and was walking slowly. MRI Tech #1 stated a walker can't be brought into the MRI room, so MRI Tech #2 helped Patient 2 into the MRI room. MRI Tech #2 stated, "I could tell he [Patient #2] had [REDACTED] so I went to assist him to get on the MRI table." MRI Tech #1 stated Patient #2 expressed some</p>	G 401	<p>Reference 1200-8-35-.04 (1) Administration</p> <p>Continued From page 11</p> <p>On 8/29/25, a code event record sheet was implemented. See Attachment E. This form will be used for all future incidents to document multiple items including when CPR was initiated and the time EMS arrived. This sheet will also be reviewed during quarterly code blue drills. In addition to this, the sheet will also be reviewed/debriefed with the entire team after a mock drill or real event by the site manager and on-site State of TN licensed RN to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. This will also be reviewed with the medical director for additional feedback or corrective action.</p> <p>The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email immediately. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. Daily checks are important to ensure the AED is functioning properly. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p> <p>The Cardiac Device Monitoring Sheet has been updated to reflect the employee's signature that performed the documentation. The sheet will be used to document vitals and when the device was placed in and out of safe mode. See Attachment C. All appropriate staff were notified of this change. To keep this deficiency from recurring, the on-site RN will monitor on a monthly basis by reviewing scanned in documents for all completed exams. In addition to this, the technologist will perform real-time monitoring by documenting when the device is placed in and out of safe mode by completing the Cardiac Device Monitoring Sheet prior to the exam, during the exam, and after the exam. This sheet will also be verified and signed off on by the second technologist or on-site RN to "double check" the device is placed in safe mode and back into normal mode. The Cardiac Device Monitoring Sheet has been updated to reflect this change, and staff were notified via email on 10/31/25. Any additional or new staff will also be trained in this process.</p>	8/29/25 9/3/25 10/31/25

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G 401	<p>Continued From page 12</p> <p><u>distress breathing when he laid down on the MRI table</u> for the scan. He stated the patient was cooperative, but asked for a few minutes to catch his breath. The MRI tech stated they gave Patient #2 a several minutes and oxygen was applied. When asked if it was common to administer oxygen to patient presenting for an MRI, he stated a lot of patients have a portable O2 tank with them. He stated MRI Tech #2 asked Patient #2 if needed oxygen, and if he used it at home, and Patient #2 indicated he did use oxygen, so MRI Tech #2 applied O2 at <input type="checkbox"/> liters via nasal cannula to Patient #2. He stated later the O2 was increased to <input type="checkbox"/> liters per minute. MRI Tech #1 stated the patients O2 sats were monitored via a rubber application to Patient #2's finger. MRI Tech #1 stated before the scan started, the patients vital were obtained and he was provided a call button in his hand to press if he needed to alert the MRI Tech during the procedure. MRI Tech #1 stated he did have to stop the procedure multiple times because Patient #2 was fidgeting with the rubber O2 monitor on his finger. MRI Tech #1 stated he would stop the scan and walk in to speak with Patient #2 face to face and explain he needed to keep his finger still for the O2 Monitor. He stated each time Patient #2 would nod and agree, and the MRI Tech would restart the scan. The MRI Tech stated during the last sequence of the scan he again went to adjust the rubber monitor on Patient #2's finger. MRI Tech #1 stated, "He [Patient #2] <u>seemed red faced and I could tell I need to finish this pretty quick.</u>" The MRI Tech stated at the end of the test, he walked into the MRI room to assist the patient and Patient #2's eyes were closed and he was non-responsive. MRI Tech #1 stated he called the patient's name and patted him lightly on his face, but the patient did not respond. The MRI Tech stated he went to get MRI Tech #2 for help and</p>	G 401	<p>Reference 1200-8-35-.04 (1) Administration</p> <p>Continued From page 12</p> <p>The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/ procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse and certified in ACLS and BLS on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p> <p>On 8/20/25, an upgraded MRI safe patient monitor was ordered. This was delivered on 10/8/25. Training for staff on this monitor occurred on 10/8/25 by the on-site nurse who is a State of TN licensed registered nurse. Any additional or new staff will also be trained by the on-site nurse. See attached training documentation (Attachment F). An MRI-safe vital signs monitor is a specially designed medical device used to continuously measure and display a patient's vital signs such as heart rate, blood pressure, oxygen saturation (SPO2), respiration rate-while the patient is inside or near an MRI scanner.</p>	<p>10/31/25</p> <p>10/8/25</p>

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G 401	<p>Continued From page 13</p> <p>told the PSR to call a code. He stated he and MRI Tech #2 got a stretcher, transferred Patient #2 to the stretcher and moved him out of the MRI room. The MRI Tech explained it is unsafe to initiate CPR in the MRI room, if anyone walked in with metal or jewelry to assist, so the patient had to be moved. MRI Tech #1 stated the EMS responders would not be able to go into the MRI area. MRI Tech #1 stated he then put the patient's defibrillator back into normal mode, rolled the patient to the CT room, transferred the patient to the CT scanner table, and MRI Tech #2 started CPR. MRI Tech #1 stated he could see the implanted defibrillator working to shock the patient. He stated the PSR was in the CT room on the telephone with 911 Operator telling her where they needed to place the pads on Patient #2 because he had an internal device. When asked if the AED worked, he stated, "<u>We didn't get the AED working...we were getting the AED on when EMS arrived.</u>" He stated "We did fiddle with the AED, but EMS arrived..." MRI Tech #1 stated he had been trained on the use of an AED. When asked how MRI Tech #2 was positioned performing CPR, he stated the CT table was lowered so MRI Tech #2 was able to stand and perform chest compressions. MRI Tech #1 stated <u>there was no policy or protocol that he was aware of when not to initiate an MRI scan, based on a patient not feeling well or having concerning vital signs and/or O2 sats.</u></p> <p>During an interview on 9/16/2025 at 11:17 AM, the former Manager of the ODC (manager at the time Patient #2 was found non-responsive in MRI machine) stated there was <u>no policy or written protocols for staff to follow on when not to perform/complete and MRI scan based on the patient's presentation, or a patient who might be experiencing an acute medical emergency.</u> The</p>	G 401	<p>Reference 1200-8-35-.04 (1) Administration Continued From page 13</p> <p>6. On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p> <p>A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation. This will allow the staff to ask any questions they may have about the SOP.</p>	<p>7/17/25</p> <p>10/31/25</p>

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G 401	<p>Continued From page 14</p> <p>former Manager stated that would be determined by the clinical technician performing the MRI scan. The former Manager stated that they obtain cardiac clearance from a cardiologist before performing the MRI scan on a patient who has an implanted device. The former Manager stated she was on paid time off on [REDACTED] when the incident occurred with Patient #2, and another Manager was acting in her absence and was notified of the event. The former Manager stated Patient #2's incident was reported to their Assistant Vice President of Operations. The former Manager stated a root cause analysis was conducted and they determined the <u>AED was an older model.</u> The former Manger stated, "the AED did work ...I think the issue was with the cords <u>..staff said they were struggling to plug pads into the device [AED]."</u></p> <p>During an interview on 9/18/2025 at 11:30 AM, the Lead PSR stated she was working on [REDACTED]. The Lead PSR stated she had no direct knowledge of the incident with Patient #2, but she was alerted to call a code/call 911 by MRI Tech #1. The Lead PSR stated Patient #2 was removed from the MRI room on a stretcher and taken to the CT room. The Lead PSR stated MRI Tech #2 was performing CPR while she was on the telephone with 911. The PSR stated she could not recall who was attempting to use the AED on Patient #2.</p> <p>During an interview on 9/16/2025 at 11:35 AM, MRI Tech #2 verified he was working on [REDACTED] when Patient #2 presented for his MRI. He stated he called Patient #2 from the waiting room, gave him a locker for any personal effects, showed him to the bathroom and then turned his implanted defibrillator into MRI Mode. MRI Tech #2 explained he used an iPad provided by the</p>	G 401	<p>Continued From page 14</p> <p>6. On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p>	7/17/25

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G 624	<p>Continued From page 17</p> <ol style="list-style-type: none"> 3. Control of hazardous materials and waste; 4. Emergency preparedness; 5. Life safety; 6. Medical equipment; and, 7. Utility systems. <p>This Rule is not met as evidenced by: Based on policy review, document review, medical record review, audio review of the 911 call, and interview, the facility failed to ensure a safe and protective environment of care for 1 of 3 (Patient #2) patients who presented to the facility for a Magnetic Resonance Imaging (MRI) and experienced a life threatening medical emergency during the MRI.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy "Emergency Crash Cart" with no effective date revealed, "...The AED defibrillator (is a portable electronic device that analyzes the heart's rhythm and delivers an electric shock to a person experiencing sudden cardiac arrest to help restore a normal heartbeat) must be plugged into the electrical outlet at all times when not in use in order to recharge the batteries...A center staff member will be responsible for checking the crash cart and completing the daily checklist which includes, at a minimum...testing the AED..." <p>Review of the facility's MRI Quality Assurance (QA) Procedure manual under the section titled, Procedure for Response to a Respiratory/Cardiac</p>	G 624	<p>1200-08-35-.06(5)(b) Basic Services.</p> <p>Continued From page 17</p> <ol style="list-style-type: none"> 1. Policies will be updated to reflect effective date as well as a reviewed date. Template attached as Attachment A. To keep this deficiency from recurring, MRI specific policies will be reviewed on an annual basis by the Governing Body and shared with all staff via email. In addition to this, if a policy is updated at any time during review it will also be shared with all staff via email. 	11/1/25

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G 624	<p>Continued From page 18</p> <p>Arrest in the Magnet Room, with no effective date revealed, "Policy: It is the policy of [named ODC] to respond promptly and appropriately in the event of a respiratory or cardiac arrest of a patient during an MRI. Procedure: 1. In the event of a respiratory or cardiac arrest of a patient during an MRI...The technologist shall immediately contact Emergency Medical Services. 2. Any center personnel in the immediate area shall be requested to provide assistance, and the magnet room shall be closed to prevent anyone from entering the MRI room without proper screening for contraindication to MRI or possession to loose magnetic objects. 3. The patient shall be transferred to the non-magnetic patient stretcher or removed from the MRI scan room by using the MRI system's removable patient table...4. The patient shall then be transported to a designated area where appropriate emergency procedures will be initiated, if any..."</p> <p>2. On [REDACTED] Patient #2's physician wrote an order for the Patient to receive a MRI scan (a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues) without contrast of [REDACTED] due to [REDACTED] Patient #2 had a pacemaker and implanted defibrillator (A pacemaker helps a slow heart rate by delivering small electrical pulses to make the heart beat at a regular pace, while a defibrillator or Implantable Cardioverter-Defibrillator, is a more advanced device that can both pace the heart and deliver a high-energy electrical shock to correct life-threatening fast or irregular heart rhythms. Both are implanted devices used to treat heart conditions, with a pacemaker providing constant support for a slow rhythm and a defibrillator</p>	G 624	<p>2. The MRI technologist RT (R) performing the exam is responsible for assessing the patients and reviewing physician orders prior to procedures. This technologist is also responsible for reviewing the patient information and screening tool prior to the procedure.</p>	10/31/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 624	<p>Continued From page 19</p> <p>acting as a safety net to prevent sudden cardiac arrest from dangerous arrhythmias).</p> <p>3. On [REDACTED] Patient #2's cardiologist wrote an order for Patient #2's Implantable Cardioverter-defibrillator device manufactured by (Named Company) to be placed in DOO safe mode during the MRI scan (DOO refers to a specific programming mode that must be activated before performing an MRI scan).</p> <p>4. On [REDACTED], Patient #2 presented to the Outpatient Diagnostic Center (ODC) for a MRI of his [REDACTED] for a diagnosis of [REDACTED]</p> <p><u>Review of the Cardiac Device Monitoring Sheet for Patient #2 dated [REDACTED] revealed at 1:30 PM Patient #2's Blood pressure (BP) was [REDACTED] and his Oxygen (O2) saturation (sat) (O2 sat) measures percent of oxygen in the blood, normal 95 - 100) was [REDACTED]%. In addition, the following O2 sats were recorded while Patient #2 was in the MRI scan:</u></p> <p>At 1:40 PM- O2 Sat- [REDACTED]%. At 1:45 PM- O2 Sat- [REDACTED]%, At 1:50 PM - O2 Sat- [REDACTED]%, At 1:58 PM- O2 Sat- [REDACTED]%, At 2:00 PM- O2 Sat- [REDACTED]%. Review of an online article by Harvard Health revealed Oxygen saturation levels in the blood indicate the amount of oxygen in the blood with normal levels ranging from 95% to 100%. Oxygen saturation refers to the percentage of hemoglobin in the blood saturated with oxygen. It is a crucial measure of how well oxygen is being transported</p>	G 624	<p>1200-08-35-.06(5)(b) Basic Services.</p> <p>Continued From page 19</p> <p>3. The MRI technologist RT (R) performing the exam is responsible for assessing the patients and reviewing physician orders prior to procedures. This technologist is also responsible for reviewing the patient information and screening tool prior to the procedure.</p> <p>4. The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse and certified in ACLS and BLS on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p> <p>On 8/20/25, an upgraded MRI safe patient monitor was ordered. This was delivered on 10/8/25. Training for staff on this monitor occurred on 10/8/25 by the on-site nurse who is a State of TN licensed registered nurse. Any additional or new staff will also be trained by the on-site nurse. See attached training documentation (Attachment F). An MRI-safe vital signs monitor is a specially designed medical device used to continuously measure and display a patient's vital signs such as heart rate, blood pressure, oxygen saturation (SPO2), respiration rate--while the patient is inside or near an MRI scanner.</p>	<p>10/31/25</p> <p>10/31/25</p> <p>10/8/25</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL5579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
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NAME OF PROVIDER OR SUPPLIER PREMIER RADIOLOGY BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 789 OLD HICKORY BLVD BRENTWOOD, TN 37027
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G 624	<p>Continued From page 20</p> <p>from the lungs to the rest of the body. Low levels are below 92% and may indicate hypoxemia, which can lead to shortness of breath, confusion and chest pain, with immediate attention needed if levels drop significantly. Dangerous low levels are below 80-85% and can severely affect brain function.</p> <p>Review of an online article by Circulation, revealed Hypoxemia is indicated if Oxygen saturation drops below 90%.</p> <p>ODC staff documented, "Placed pt [patient] out of surescan [implanted cardiac defibrillator device taken out of MRI DOO safe mode] after stretched! [Patient was placed on a stretcher]" <u>There was no staff signature on the Cardiac Device Monitoring Sheet to determine who completed the documentation.</u></p> <p>5. The Assistant Vice President (AVP) downloaded the data information from the MRI SureScan and provided the report to the surveyor. The AVP stated this data would have to be interpreted by (Named Company) and she did not know what the data meant. Please refer to the interview below with the (Named Company) Manager who interpreted the data as showing Patient #2's implanted defibrillator device was not turned on to surescan DOO mode on [REDACTED] until 2:39 PM (37 minutes after the 911 call was made to report Patient #2 was unresponsive).</p> <p>6. Review of the handwritten statement by MRI Tech #1 revealed the following: "Pt [Patient #2] brought into scan room 1:35 PM. When [named MRI Tech #2] placed him [Patient #2] on [MRI] table he [Patient #2] expressed difficulty breathing. He was then put on O2- [REDACTED] [liters refers to a flow rate of [REDACTED] liters per minute of</p>	G 624	<p>Continued From page 20</p> <p>4. The Cardiac Device Monitoring Sheet has been updated to reflect the employee's signature that performed the documentation. The sheet will be used to document vitals and when the device was placed in and out of safe mode. See Attachment C. All appropriate staff were notified of this change. To keep this deficiency from recurring, the on-site RN will monitor on a monthly basis by reviewing scanned in documents for all completed exams. In addition to this, the technologist will perform real-time monitoring by documenting when the device is placed in and out of safe mode by completing the Cardiac Device Monitoring Sheet prior to the exam, during the exam, and after the exam. This sheet will also be verified and signed off on by the second technologist or on-site RN to "double check" the device is placed in safe mode and back into normal mode. The Cardiac Device Monitoring Sheet has been updated to reflect this change, and staff were notified via email on 10/31/25. Any additional or new staff will also be trained in this process.</p> <p>6. The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p>	<p>10/31/25</p> <p>10/31/25</p>

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G 624	<p>Continued From page 22</p> <p>9. Emergency medical services (EMS) arrived at Patient #2's bedside on [REDACTED] at 2:10 PM. EMS documented, "...dispatched to cardiac or respiratory arrest. Upon arrival to scene, patient is laying on MRI machine table unresponsive, cyanotic, no breathing and no pulse. He is receiving some CPR and has nasal cannula and AED attached. <u>Staff reports AED does not work.</u> EMS transferred Patient #2 to the hospital and performing CPR while en route. Patient #2 remained in pulseless electrical activity ((PEA) - is a critical condition where the heart's electrical system functions normally, but the heart muscle does not contract effectively to produce a pulse; leads to cardiac arrest) a second dose of [REDACTED] was administered. Patient #2's care was transitioned to the Emergency Department (ED) staff at Hospital #1, while CPR continued on [REDACTED] at 2:30 PM.</p> <p>10. Review of Patient #2's History and Physical from Hospital #1 revealed, "...presents from outpatient MRI according to EMS after witnessed cardiac arrest...EMS states when they arrived there was bystander CPR. They checked and pt was in Vfib [ventricular fibrillation - a life-threatening cardiac arrhythmia where the heart's lower chambers quiver chaotically instead of beating normally, leading to a failure to pump blood to the body] got shocked one time, PEA after that...what I suspect happened is patient had a hypoxic arrest while lying flat in MRI likely result of [REDACTED]...Pt may have also had a cardiac event while his defibrillator was turned to pacemaker mode for the MRI..."</p> <p>Patient #2 was admitted to the hospital after being intubated and placed on mechanical ventilator. Patient #2 remained [REDACTED] with</p>	G 624	<p>1200-08-35-.06(5)(b) Basic Services.</p> <p>Continued From page 22</p> <p>9. On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p>	7/17/25

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G 624	<p>Continued From page 23</p> <p>██████████ pupils and ██████████ at the hospital on ██████████ at 9:07 PM.</p> <p>11. During an interview on 9/3/2025 at 2:55 PM, the AVP stated the <u>facility did not have an exact time when CPR was initiated for Patient #2</u>, or a time when EMS arrived, so they did not include that information in their timeline of events with the root cause analysis.</p> <p>During an interview on 9/3/2025 at 3:25 PM, the AVP provided the survey team with the monthly AED checks for 2025. The AVP stated, "<u>We should have been checking it [the AED] daily [per facility policy above], but we have never been cited that by the State [survey agency]</u>".</p> <p>During an interview on 9/17/2025 at 10:44 AM, MRI Tech #1 stated Patient #2 presented to the ODC on ██████████ for an MRI of his ██████████. MRI Tech #2 stated his colleague, MRI Tech #2 retrieved Patient #2 from the waiting room, took the Patient's initial vital signs, and put the implanted device (pacemaker- defibrillator) in MRI safe mode. MRI Tech #1 stated they follow the manufacturer instructions, in this case the (Named Company) used an iPad to put the device in safe mode for the MRI procedure. MRI Tech #1 stated after the device was placed in safe mode the iPad prompts the tech to ask the patient if they feel comfortable. MRI Tech #1 <u>stated he did not observe MRI Tech #2 doing this</u>, as he was at his console finishing with another patient. MRI Tech #1 stated his first observation of Patient #2 was when MRI Tech #2 was walking the patient into the MRI area/room. MRI Tech #1 stated the patient ██████████ was walking slowly. MRI Tech #1 stated a ██████████ can't be brought into the MRI room, so MRI Tech #2 helped Patient 2 into the MRI room. MRI Tech #2</p>	G 624	<p>1200-08-35-.06(5)(b) Basic Services.</p> <p>Continued From page 23</p> <p>11. On 8/29/25, a code event record sheet was implemented. See Attachment E. This form will be used for all future incidents to document multiple items including when CPR was initiated and the time EMS arrived. This sheet will also be reviewed during quarterly code blue drills. In addition to this, the sheet will also be reviewed/debriefed with the entire team after a mock drill or real event by the site manager and on-site State of TN licensed RN to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. This will also be reviewed with the medical director for additional feedback or corrective action.</p> <p>The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email immediately. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. Daily checks are important to ensure the AED is functioning properly. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p>	<p>8/29/25</p> <p>9/3/25</p>

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G 624	<p>Continued From page 24</p> <p>stated, "I could tell he [Patient #2] had [REDACTED], so I went to assist him to get on the MRI table." MRI Tech #1 stated Patient #2 expressed some <u>distress breathing when he laid down on the MRI table for the scan.</u> He stated the patient was cooperative, but asked for a few minutes to catch his breath. The MRI tech stated they gave Patient #2 a several minutes and oxygen was applied. When asked if it was common to administer oxygen to patient presenting for an MRI, he stated a lot of patients have a portable O2 tank with them. He stated MRI Tech #2 asked Patient #2 if needed oxygen, and if he used it at home, and Patient #2 indicated he did use oxygen, so MRI Tech #2 applied O2 at [REDACTED] liters via nasal cannula to Patient #2. He stated later the O2 was increased to [REDACTED] liters per minute. MRI Tech #1 stated the patients O2 sats were monitored via a rubber application to Patient #2's finger. MRI Tech #1 stated before the scan started, the patients vital were obtained and he was provided a call button in his hand to press if he needed to alert the MRI Tech during the procedure. MRI Tech #1 stated he did have to stop the procedure multiple times because Patient #2 was fidgeting with the rubber O2 monitor on his finger. MRI Tech #1 stated he would stop the scan and walk in to speak with Patient #2 face to face and explain he needed to keep his finger still for the O2 Monitor. He stated each time Patient #2 would nod and agree, and the MRI Tech would restart the scan. The MRI Tech stated during the last sequence of the scan he again went to adjust the rubber monitor on Patient #2's finger. MRI Tech #1 stated, "He [Patient #2] seemed red faced and I could tell I need to finish this pretty quick." The MRI Tech stated at the end of the test, he walked into the MRI room to assist the patient and Patient #2's eyes were closed and he was non-responsive. MRI Tech #1 stated he called the</p>	G 624	<p>Continued From page 24</p> <p>11. The Cardiac Device Monitoring Sheet has been updated to reflect the employee's signature that performed the documentation. The sheet will be used to document vitals and when the device was placed in and out of safe mode. See Attachment C. All appropriate staff were notified of this change. To keep this deficiency from recurring, the on-site RN will monitor on a monthly basis by reviewing scanned in documents for all completed exams. In addition to this, the technologist will perform real-time monitoring by documenting when the device is placed in and out of safe mode by completing the Cardiac Device Monitoring Sheet prior to the exam, during the exam, and after the exam. This sheet will also be verified and signed off on by the second technologist or on-site RN to "double check" the device is placed in safe mode and back into normal mode. The Cardiac Device Monitoring Sheet has been updated to reflect this change, and staff were notified via email on 10/31/25. Any additional or new staff will also be trained in this process.</p> <p>The MRI technologist RT (R) performing the exam is responsible to ensure the patient's vital signs and O2 saturation are within acceptable parameters for the procedures. A SOP will be created and approved by the Medical Director to ensure staff know how to appropriately handle patients that are experiencing physiological changes/status changes. This SOP will include the process/procedure on how to access vital signs and what to do if there is a variation in their initial baseline assessment. The technologist (Registered Technologist RT (R)) performing the exam will be responsible in determining if a patient is experiencing a status change. The technologist is instructed to consult with the medical director or available radiologist if a status change occurs. If a nurse is available, the patient will be assessed by them as well if experiencing low O2 sats and SOB.</p> <p>As outlined in the SOP, the criteria used to determine if the patient is stable or not stable is heart rate, blood pressure, oxygen saturation (SpO2) and respiration rate. The medical director has developed this criteria and the staff will be educated by the on-site RN who is a State of TN licensed registered nurse and certified in ACLS and BLS on 10/31/25. In addition to this, any patient determined to be unstable will have their case reviewed with the medical director to ensure the appropriate processes were followed and to provide feedback or corrective action as needed. The SOP will be presented to the staff by the site manager/on-site nurse during a staff meeting on 10/31/25. This staff meeting will occur prior to implementation of the SOP. This will allow the staff to ask any questions they may have about the SOP.</p> <p>On 8/20/25, an upgraded MRI safe patient monitor was ordered. This was delivered on 10/8/25. Training for staff on this monitor occurred on 10/8/25 by the on-site nurse who is a State of TN licensed registered nurse. Any additional or new staff will also be trained by the on-site nurse. See attached training documentation (Attachment F). An MRI-safe vital signs monitor is a specially designed medical device used to continuously measure and display a patient's vital signs such as heart rate, blood pressure, oxygen saturation (SPO2), respiration rate--while the patient is inside or near an MRI scanner.</p>	<p>10/31/25</p> <p>10/8/25</p>
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G 624	<p>Continued From page 26</p> <p>perform/complete and MRI scan based on the patient's presentation, or a patient who might be experiencing an acute medical emergency. The former Manager stated that would be determined by the clinical technician performing the MRI scan. The former Manager stated that they obtain cardiac clearance from a cardiologist before performing the MRI scan on a patient who has an implanted device. The former Manager stated she was on paid time off on [REDACTED] when the incident occurred with Patient #2, and another Manager was acting in her absence and was notified of the event. The former Manager stated Patient #2's incident was reported to their Assistant Vice President of Operations. The former Manager stated a root cause analysis was conducted and they determined the <u>AED was an older model</u>. The former Manger stated, " the AED did work ...I think the issue was with the cords...staff said they were struggling to plug pads into the device [AED]".</p> <p>During an interview on 9/18/2025 at 11:30 AM, the Lead PSR stated she was working on [REDACTED]. The Lead PSR stated she had no direct knowledge of the incident with Patient #2, but she was alerted to call a code/call 911 by MRI Tech #1. The Lead PSR stated Patient #2 was removed from the MRI room on a stretcher and taken to the CT room. The Lead PSR stated MRI Tech #2 was performing CPR while she was on the telephone with 911. The PSR stated she could not recall who was attempting to use the AED on Patient #2.</p> <p>During an interview on 9/16/2025 at 11:35 AM, MRI Tech #2 verified he was working on [REDACTED] when Patient #2 presented for his MRI. He stated he called Patient #2 from the waiting room, gave him a locker for any personal effects,</p>	G 624	<p>Continued From page 26</p> <p>11. On 7/17/25, a new, battery operated and user friendly AED and pads were delivered. All staff were trained on how to operate the new AED on 7/17/25 by the on-site State of TN licensed RN who is certified in ACLS and BLS. AED training will occur every quarter during Code Blue Drills. See attached training documentation (Attachment B). New staff will be trained upon hire. The AED is now checked daily per our policy by the on-site State of TN licensed RN. Staff responsibilities are discussed during code drills each quarter to ensure all staff are aware of responsibilities. New staff will be informed upon hire. If there is a change in the staff member, all staff will be notified via email. A back up staff member is also assigned in the case the assigned staff member is out of the office. To keep this deficiency from recurring, the site manager will complete weekly rounds for two months to review the checklist to ensure it is being completed, then monitor monthly. Once reviewed, initials from the site manager will be placed weekly and/or monthly next to the completed documentation. If the AED is malfunctioning during the daily check, the staff are instructed to reach out to the site manager who will then troubleshoot the issue and source for replacement if needed. The AED will also be placed out of service until the issue is resolved, or a new unit is delivered.</p>	7/17/25

Redaction Log

Total Number of Redactions in Document: 101

Redaction Reasons by Page

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21			3
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23			5
24			10
25			4
27			3
29			1