WRITTEN COMMENTS ON 2024 BUNCOMBE-GRAHAM-MADISON-YANCEY MULTICOUNTY ACUTE CARE BED COMPETITIVE REVIEW

SUBMITTED BY ADVENTHEALTH ASHEVILLE, INC. & ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION

July 31, 2024

Three applicants submitted CON applications in response to the need identified in the 2024 SMFP for 26 additional acute care beds in the Buncombe, Graham, Madison, and Yancey multicounty service area. The applicants include:

- CON Project ID# B-12518-24 Mission Hospital
- CON Project ID# B-12526-24 AdventHealth Asheville
- CON Project ID# B-12520-24 Novant Health Asheville Medical Center

AdventHealth Asheville, Inc. and Adventist Health System Sunbelt Healthcare Corporation (collectively, "AdventHealth Asheville") submit these comments in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including their respective abilities to conform with applicable statutory and regulatory review criteria and a discussion of the prospective comparative analysis of the applicable and most significant issues concerning this competitive batch review. Other non-conformities in the competing applications may exist and AdventHealth Asheville may develop additional opinions, as appropriate upon further review and analysis.

	AdventHealth Written Comments Begin on Page #
Novant Health Asheville Medical Center (NHAMC) Project I.D. B-12520-24	2
Mission Hospital (Mission) Project I.D. B-12518-24	14
Comparative Analysis	25

COMMENTS SPECIFIC TO NOVANT HEALTH ASHEVILLE MEDICAL CENTER (NHAMC) PROJECT ID No. B-012520-24

Novant Health Asheville Medical Center's (NHAMC) application cannot be approved because it lacks critical financial information. NHAMC has an agreement to purchase a single licensed operating room (OR) from Outpatient Surgery Centers of Asheville (OSCA). This proposed purchase and relocation necessitates CON approval, differing significantly from NHAMC's 2022 proposal, which involved no financial transaction. Notably, the 2024 application fails to include the required financial details regarding this acquisition. Thus, as described in detail in the following pages, NHAMC's application should be found nonconforming with multiple review criteria.

Proposed Development of One (1) OR Via Purchase and Relocation from OSCA

NHAMC's proposed project involves the development of one (1) licensed operating room. The 2024 SMFP does not include a need determination for any ORs in the applicable service area. Thus, to develop its project as proposed, NHAMC must relocate an OR from an existing facility.

As stated on application page 37, "NH Asheville has an agreement in place to purchase one operating room from Outpatient Surgery Centers of Asheville if it receives approval for this CON application." Exhibit C-1.12 includes a letter from Surgery Partners that states, "OSCA and Novant Health have entered into an agreement that allows Novant Health to purchase one of OSCA's five ORs after it has received CON approval for NH Asheville Medical Center and any appeals have been resolved."

Both the purchase, and the relocation, of an OR requires a certificate of need.

NHAMC's 2024 application markedly differs from NHAMC's 2022 proposal (Project ID #B-12230-22), which also sought to relocate an OR from OSCA but did not include a financial transaction. Notably, Surgery Partners was a co-applicant in the 2022 application but is absent in the 2024 application. Furthermore, the 2022 application did not classify the OR relocation as an operating expense or capital expenditure, unlike the explicit purchase agreement in the 2024 application. The 2024 project description necessitates including the financial obligations in the project capital cost, a requirement not met by the current application.

Under NCGS 131E-176(16)(l), "New Institutional Health Service" is defined to include: The **purchase**, lease, or acquisition of any health service facility**, or portion thereof**, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E-180.

Additionally, under NCGS 131E-176(16)(u), "New Institutional Health Service" includes: The construction, development, establishment, increase in the number**, or relocation of an operating room** or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

NHAMC cannot relocate an OR from OSCA to the proposed new hospital without CON approval as documented by numerous Agency decisions, e.g. Project ID #F-012255-22 Atrium Health Harrisburg,

Project ID #J-11508-18 Duke Ambulatory Surgery Center Arringdon, Project ID #L-012005-20 Wilson Surgery Center, and Project ID # F-11906-20 Gateway Surgery Center.

The development of a new institutional health service requires a CON. Even if Project I.D. #B-012520-24 could constitute the CON application required to relocate the OSCA operating room, which it does not purport to be, it is missing all of the information required to demonstrate a need to restrict a general OR to cancer-only use.

Moreover, the 2024 NHAMC application fails to include any of the required information regarding the financial obligations to "purchase one operating room from Outpatient Surgery Centers of Asheville if it receives approval for this CON."[1] The applicants specifically referenced a financial transaction related to the OSCA OR relocation, i.e., purchase, therefore, the associated capital expense must be included in the project capital cost. Likewise, the details of the purchase and relocation must be included in the application.

As defined in the CON application form, the term "capital cost" has the same meaning as the term "capital expenditure" which is defined in G.S. 131E-176(2d) as *"An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase."*

The expenditure for NHAMC's project includes the purchase of one OR from OSCA. However, Form F.1 Capital Cost fails to include NHAMC's financial obligation to acquire this asset. NHAMC cannot develop the proposed OR without requesting CON approval for the capital expenditure related to development of the respective service.

A pertinent comparison is Project ID #F-12489-24, where Windsor Run, LLC, included the financial obligation for purchasing relocated ACH beds in their capital cost. Windsor Run, LLC, proposed to develop a new 96 bed adult care home (ACH) facility by developing 86 ACH beds pursuant to Policy LTC-1 and relocating 10 existing ACH beds from Pineville Rehabilitation and Living Center. Windsor Run, LLC proposed to purchase the 10 ACH beds from Pineville Rehabilitation and Living Center.[2] Accordingly, Windsor Run, LLC included the financial obligation related to the bed purchase in Form F.1 Capital Cost.[3] The Agency Findings for Project ID #F-12489-24 appropriately recognize the applicable capital expenditure for the proposed 10 ACH beds under Criterion (5).[4]

In its 2022 application for acute care beds in Buncombe County, Novant did not propose to purchase the OR and stated "there is nothing about the contribution of the operating room to NH Asheville that constitutes either an operating expense or a capital expenditure."[5] However, because of the substantial differences between the 2022 and 2024 projects, especially regarding the explicit financial transaction for

[1] NHAMC application (B-012520-24) page 37
[2] Project ID #F-12489-24, pages 21, 29, 49
[3] Project ID #F-12489-24, page 93
[4] Agency Findings Project ID #F-12489-24, page 15
[5] NH Asheville (B-12230-22) response to comments submitted by AdventHealth Asheville, page 2

the OR purchase, this claim regarding the 2022 proposal does not hold true in this review. The 2024 application explicitly involves a purchase agreement for an OR, which constitutes a clear capital expenditure and a new institutional health service as a component of the Novant application. Without accurately including this financial expenditure in the 2024 application, NHAMC cannot develop the proposed OR. Therefore, the NHAMC application should be found nonconforming with Criteria (5) and (12).

Now that NHAMC has proposed to develop an OR at its proposed facility, it cannot amend or change the scope of their application during the review, especially when they have affirmatively stated they are entering into a capital expenditure to acquire an OR from OSCA. NHAMC cannot now say that the OR does not need to be purchased - such an argument would undermine the need for the project proposed, resulting in nonconformity with Criterion (3).

Limited Scope of Clinical Services Offered at NHAMC

NHAMC states that it will be a "cancer and surgery-focused community hospital in Buncombe County….two cancer-focused physician practices, Messino Cancer Centers ("MCC"), and NH Surgical Partners – Biltmore ("NHSPB"), support this project and will treat the majority of their patients at NH Asheville."[6] NHAMC's methodology for projecting inpatient days of care is based "only on these physicians' commitments."[7]

NHAMC reviewed July 2022 to June 2023 discharges and days of care for MCC physicians and CY2023 discharges and days of care for NHSPB physicians. The analysis counted only discharges from Buncombe and Henderson County hospitals. NHAMC projected respective discharges and days of care to increase at a compound annual growth rate (CAGR) of 0.89% per year from 2023 to 2031. NHAMC projects MCC physicians will treat 75% of their patients at NHAMC and NHSPB physicians will treat 85% of their patients at NHAMC. NHAMC's methodology results in the following projected utilization.

MCC and NHSPB Projected Patient Days CY 2024–2031
Treated at NH Asheville NH Asheville

	Base Year	2024	2025	2026	2027	2028	2029	2030	2031
MCC	6,093	6,147	6,202	6,257	6,313	6,369	6,426	6,483	6,541
NHSPB	2,269	2,289	2,309	2,330	2,351	2,372	2,393	2,414	2,435
MCC %						75%			
NHSPB %						85%			
MCC Days at NH Asheville						4,777	4,820	4,862	4,906
NHSPB Days at NH Asheville						2,016	2,034	2,052	2,070
Total Inpatient Days at NH Asheville						6,793	6,854	6,914	6,976

*Sources: HIDI Data, Steps 1–3. *Partial Year is accounted for in next step.*

Source: NHAMC application page 116

[6] NHAMC application page 162
[7] ibid

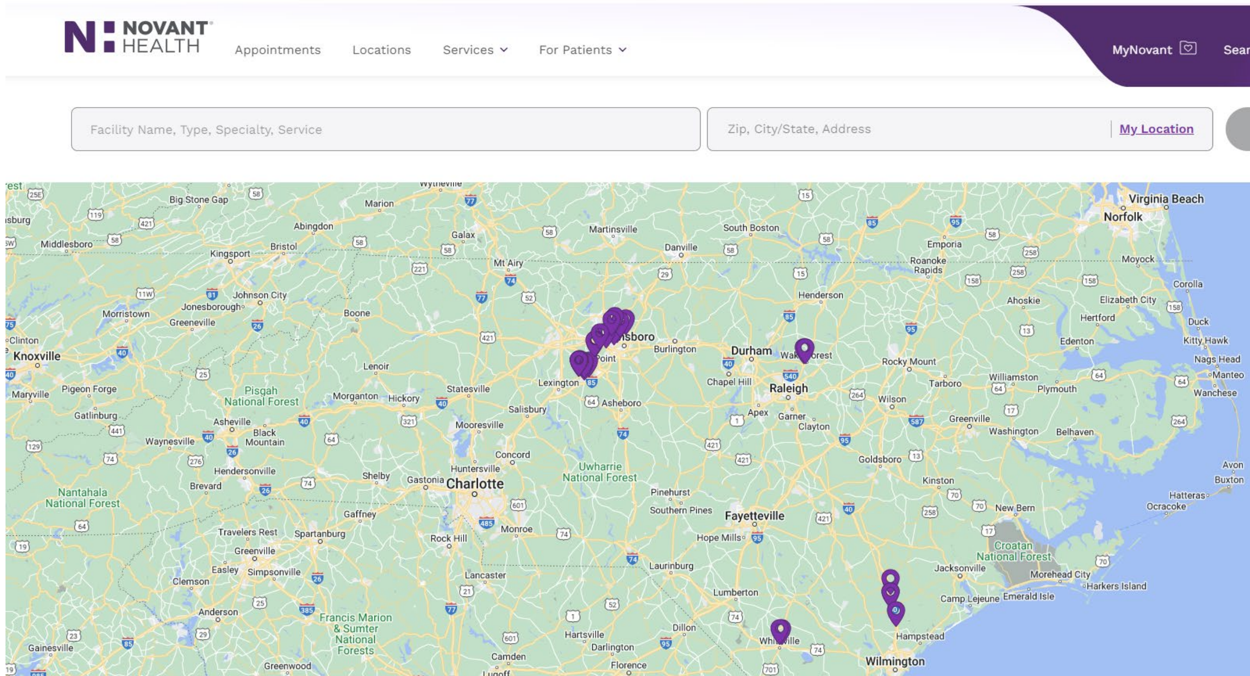
NHAMC's projected utilization is specifically based upon MCC's and NHSPB's historical patient utilization, which are primarily cancer patients. **NHAMC does not provide any data to support a scope of acute care services beyond cancer care**. This is a critical detail because it limits NHAMC's ability to enhance access and competition in the market.

NHAMC will not offer the following services: cardiology, neurology, orthopedics, labor and delivery, pediatrics, and ophthalmology. Therefore, NHAMC's project will not enhance access for patients needing these services. As a full-service hospital, AdventHealth Asheville will provide acute care services across a broad range of specialties effectively enhancing access for patients that require inpatient care.

NHAMC states that it will have a fully equipped emergency department, that it will treat all clinically appropriate patients who arrive at the hospital, and will transfer any who require a higher level of care. However, NHAMC will not have the means to *actually treat* the most common types of patients that present to an ED. NHAMC does not demonstrate that it will have cardiologists, neurologists, or orthopaedic physicians on its medical staff or taking call at the proposed ED. Thus, NHAMC will not have the means to treat patients presenting with chest pain, heart attack, stroke symptoms, bone fractures, labor complications, etc. NHAMC's emergency physicians may only stabilize these patients and refer them to another acute care facility for treatment. This limitation raises legitimate concerns about the overall effectiveness and readiness of NHAMC's ED to handle emergency situations adequately, potentially impacting patient outcomes and continuity of care.

Novant Health does not maintain transfer agreements with any acute care facilities in western North Carolina. NHAMC states "Buncombe County Emergency Medical Services (EMS) or NH Critical Care Transport will transport patients requiring a higher level of care than NH Asheville can provide to an appropriate facility.[8] However, Buncombe County EMS did not provide a letter of support for NHAMC's application. As shown on the following map obtained from the NH Critical Care Transport website, Novant Health does not operate Critical Care Transport services in western NC.

[8] NHAMC application page 37



While Novant Health has experience in providing cancer services across its existing facilities, it lacks specific expertise in developing and operating a specialized, small-scale cancer-focused hospital. Novant Health's smallest community hospital in North Carolina, NH Mint Hill, is a full-service 36-bed hospital that provides a broad range of medical services.

The proposed scope of the cancer-focused hospital appears to be driven primarily by the interests and commitments of two physician practices, rather than an in-depth analysis of the service area's specific healthcare needs. This approach raises concerns about whether the facility's scope truly aligns with the service area's need for acute care services.

Criterion (1) "*The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved*."

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Novant Health fails to conform with Review Criterion (1) and Policy GEN-3 because the application does not conform to all other applicable statutory and regulatory review criteria and is thus not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding Criteria (3), (4), (5), (6), (7), (12), (13c) and (18a). Therefore, the application does not conform to this criterion and cannot be approved.

Criterion 3 "*The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed*."

ED Utilization Assumptions

NHAMC's assumptions for projecting emergency department utilization are flawed and unreasonable.

As previously described, NHAMC states that it will be a "cancer and surgery-focused community hospital in Buncombe County….two cancer-focused physician practices, Messino Cancer Centers ("MCC"), and NH Surgical Partners – Biltmore ("NHSPB"), support this project and will treat the majority of their patients at NH Asheville."[9]

NHAMC projects its outpatient ED utilization, in part, based on the historical volume and percentage of MCC and NHSPB patients that "were first seen in the ED."[10] During 2023, a total of only 31 MCC and NHSPB patients came through the ED.

	No ER Flag	ER Flag	Grand Total	% Through ER
MCC	4,228	21	4,249	0.49%
NHSPB	1,838	10	1,848	0.54%

Source: HIDI Outpatient Database, CY 2023

Source: NHAMC application page 188

Based on these historical percentages, NHAMC projects a total of only 26 outpatient ED visits from MCC and NHSPB patients.

NHAMC projects its inpatient ED utilization, in part, based on the historical volume and percentage of MCC and NHSPB patients that "were first seen in the ED."[11] NHAMC applied the historical percentages to the projected inpatient discharges in Form C.1b.

[9] NHAMC application page 162
[10] NHAMC application page 188
[11] NHAMC application page 189

Expected Inpatient ED Visits

		2028	2029	2030	2031
A	MCC IP Discharges Treated at NH Asheville	51	621	626	632
B	MCC IP Historical ED Percent	68.58%	68.58%	68.58%	68.58%
*C=A*B*	Resulting Inpatient ED Visits	35	426	429	433
D	NHSPB IP Discharges Treated at NH Asheville	33	397	400	404
E	NHSPB Historical ED Percent	18.51%	18.51%	18.51%	18.51%
*F=D*E*	Resulting Inpatient ED Visits	6	73	74	75
G=F+C	**Total Inpatient ED Visits**	**41**	**499**	**503**	**508**

Sources: Form C.1b, HIDI Inpatient Database

NHAMC describes that Novant Health has implemented a system at Presbyterian Medical Center in Charlotte that allows oncology patients with acute symptoms to bypass the ED and receive care on the oncology floor.[12] Based on Novant Health's experience, approximately half of the oncology patients who present in the ED are candidates for the ED bypass program. NHAMC will implement a similar ED bypass program. Therefore, approximately half of the projected ED visits from MCC and NHSPB patients would instead bypass the ED, which would reduce NHAMC's projected ED volume and revenue from MCC and NHSPB patients substantially. NHAMC did not provide Forms F.2 or F.3 for its emergency department; thus, there is insufficient information in the application as submitted to evaluate whether the facility would remain financially viable.

Also, NHAMC unreasonably assumes that 10 percent of Mission's ED patients discharged to home or self-care and residing in zip codes 28806, 28803, 28715, 28704, 28742, and 28759 will be served at the proposed cancer-focused hospital ED.

As previously noted, NHAMC will not have the capability to treat the most common types of patients who visit an emergency department. The facility does not show evidence of having cardiologists, neurologists, obstetricians, or orthopedic physicians on its medical staff or available on-call at the proposed ED. Consequently, NHAMC will be unable to treat patients presenting with conditions such as chest pain, heart attacks, stroke symptoms, bone fractures, and labor complications. The emergency physicians at NHAMC may only be able to stabilize these patients before referring them to another acute care facility for further treatment.

Furthermore, NHAMC has not provided a reasonable explanation for why it expects patients with non-cancer-related emergencies—such as chest pain, heart attacks, stroke symptoms, bone fractures, or labor complications—to choose an emergency department located at a hospital primarily marketed as a cancer treatment facility.

NHAMC also failed to acknowledge or account for the conditional approval of Mission's CON applications for freestanding EDs, i.e. one in Arden (Project I.D. B-012191-22) and one in Candler (Project I.D. B-12380-23). While AdventHealth is appealing the decisions, the burden remains on the applicant to address

[12] NHAMC application page 75

approved but not operational projects given the similarity of the services offered. NHAMC's proposed ED will be similar to Mission's freestanding emergency department because the majority of patients needing inpatient admissions at NHAMC will need to be transferred to another facility. Novant Health failed to address what impact, if any, the approved freestanding ED projects will have on its projected ED utilization. Therefore, NHAMC's projected ED utilization is unreliable.

Proposed Operating Room

Form C.3b "Projected OR and GI Endo Room Utilization upon Project Completion" reflects one (1) OR and approximately 1,500 surgical cases performed at NHAMC during each of the first three project years. Thus, Form C.3b indicates the projected surgical cases will be performed in the proposed OR. NHAMC's projected utilization indicates a need for 1.44 ORs during the third project year. However, NHAMC states that it could perform surgical cases in any of the four OR/PR rooms.[13] If some or all of the surgical volume is performed in NHAMC's procedure rooms, utilization in the OR would necessarily decrease, reducing the number of ORs needed in Form C.3b. Absent projected utilization of the proposed procedure rooms, projected utilization of the OR is unknown. Consequently, the applicant fails to demonstrate the need it has for the proposed relocated OR.

Additionally, NHAMC projects to shift 10 percent of outpatient surgical emergency department volume from Mission Hospital.[14] However, the outpatient surgical emergency department volume from Mission Hospital will not be limited to cancer-related conditions. NHAMC does not demonstrate that it will have cardiologists, neurologists, obstetricians, or orthopaedic physicians on its medical staff or taking call at the proposed ED to accommodate the surgical needs of those patients presenting to the NHAMC ED. Therefore, projected surgical utilization is unreasonable and not supported.

For these reasons, Novant Health does not demonstrate that projected utilization is reasonable and adequately supported. If projected utilization is not reasonable and adequately supported, the applicant has failed to fulfill its burden of demonstrating the need it has to develop the project. Consequently, the Novant Health application does not conform to Criterion (3).

Criterion 4 "*Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed*."

The NHAMC application does not conform to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative.

The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application does not conform to this criterion and cannot be approved. See discussion regarding Criteria (1), (3), (5), (6), (12), and (18a).

Criterion 5 "*Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal,*

[13] Project ID #F-12489-24, page 177
[14] Based on the parameters identified on application page 179

based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."

Based on the facts described in these written comments specific to Criterion (3) (incorporated herein by reference), these facts result in the NHAMC application being non-conforming to Criterion (5).

As previously described in detail, the NHAMC application fails to include the financial obligations to purchase one OR from OSCA. The applicants specifically referenced a financial transaction related to the OSCA OR relocation, i.e., purchase, therefore, the associated capital expense must be included in the project capital cost. Absent this pertinent information, the application does not conform to Criterion (5).

NHAMC states its medical staff will be available onsite and through telemedicine.[15] However, there are no expenses for telemedicine in ED reflected in Form F.3. "Other Expenses" references On-Call payments, Medical Director pay, and inpatient hospitalist, but does not reference telemedicine.

NHAMC states it will contract with Apollo MD for ED physician services.[16] However, NHAMC does not appear to have fully accounted for the necessary operational expenses to provide emergency services 24/7. The Form F.3 assumptions for "Independent Contractors" state the expenses are based on the inpatient DRG. NHAMC projects only 19 percent of its ED visits will be associated with an inpatient admission (508 ÷ 2,586).[17] Thus, if the expenses for ED physician services are included in "Independent Contractors" then they reflect only a fraction of the required projected expenses. There is no assumption to describe the allocation for ED physician services associated with the 81 percent of ED utilization that is strictly outpatient.

NHAMC states it will contract for neonatal physician coverage.[18] However, NHAMC does not appear to have accounted for the necessary operational expenses to provide neonatal physician coverage. Form F3 assumptions for "Independent Contractors" and "Other Expenses" state the expenses are based on the inpatient DRG and adjusted for volume. NHAMC did not project any inpatient discharges associated with neonatology; therefore, there are similarly no costs accounted for neonatal coverage.

Criterion 6 "*The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities*."

The applicant is not conforming to all statutory and regulatory review criteria, thus it cannot demonstrate that its proposal is needed in addition to the existing and approved health service capabilities or facilities in the multicounty service area.

NHAMC also failed to acknowledge or account for the conditional approval of Mission's CON applications for freestanding EDs, i.e. one in Arden (Project I.D. B-012191-22) and one in Candler (Project I.D. B-12380-23). While AdventHealth is appealing the decisions, the burden remains on the applicant to address approved but not operational projects given the similarity of the services offered. NHAMC's proposed ED

[15] NHAMC application page 37
[16] NHAMC application page 39
[17] NHAMC application page 190
[18] NHAMC application page 39

will be similar to Mission's freestanding emergency department because the majority of patients needing inpatient admissions at NHAMC will need to be transferred to another facility. Novant Health failed to address what impact, if any, the approved freestanding ED projects will have on its projected ED utilization.

For these reasons, the application does not conform with Criterion (6).

Criterion 7 *"The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided."*

NHAMC application page 33 states "Other outpatient services - includes emergency department services." However, as shown in the following table, Form H Staffing does not include any staff for NHAMC's other outpatient services.

Form H Staffing Criterion (7)	Current Staff As of 06/15/2024			Projected Staff								
				First Full Fiscal Year			Second Full Fiscal Year			Third Full Fiscal Year		
Include employees, contract employees and temporary employees but not independent contractors	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *	# of FTEs	Average Annual Salary per 1 FTE**	Total Salary *
NH Asheville- OP Other	B	C	D=B*C	E	F	G=E*F	H	I	J=H*I	K	L	M=K*L
CRNAs	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Nurse Practioners	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Registered Nurses	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Licensed Practical Nurses	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Surgical Technicians	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Aides/Orderlies	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Clerical Staff	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Anesthesiologists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Pathologists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Laboratory Technicians	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Radiologists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Radiology Technologists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Pharmacists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Pharmacy Technicians	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Physical Therapists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Physical Therapy Assistant	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Physical Therapy Technician	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Speech Therapists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Occupational Therapists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Respiratory Therapists	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Respiratory Therapy Technicians	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Dieticians	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Cooks	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Dietary Aides	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Social Workers	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Medical Records	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Laundry & Linen	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Housekeeping	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Central Sterile Supply	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Bio-medical Engineering	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Materials Management	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Maintenance/Engineering	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Administrator	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Director of Nursing	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Chief Financial Officer	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Business Office	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Other (Health Educator)	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Other (Public Safety)	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Other (Sleep Technologist)	0.0	0	$0	0.0	0	$0	0.0	0	$0	0.0	0	$0
Total	0.0		$0	0.0		$0	0.0		$0	0.0		$0

*Exclusive of taxes and benefits
State the percentage of total salary projected for taxes and benefits: ____22.1_______%
Applicants may delete rows for position types not applicable to the type of facility identified in response to Section A, Question 4.
Applicants may add rows for position types not listed.

Source: NHAMC application page 213

NHAMC's Form H Assumptions state, "Other Outpatient Services Form H – There are no positions that are solely dedicated to other outpatient services. Support services like lab, imaging, pharmacy, etc. support all inpatient services, outpatient surgery services, and other outpatient services."[19]

[19] NHAMC application page 217

NHAMC may respond by stating the ED staff are included in Form H for inpatient services; however, that would be contrary to its previous discussion of ED services being included in other outpatient services. Furthermore, NHAMC projects only 19 percent of its ED visits will be associated with an inpatient admission (508 ÷ 2,586).[20] The vast majority of NHAMC ED services will be associated with an outpatient visit. Thus, it appears that NHAMC has not accounted for the necessary ED staff and associated costs.

For these reasons, the application does not conform with Criteria (5) and (7).

Criterion (12) *"Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans."*

As previously described in detail, the NHAMC application fails to include the financial obligations and details related to the purchase one OR from OSCA. The applicants specifically referenced a financial transaction related to the OSCA OR relocation, i.e., purchase, therefore, the associated capital expense must be included in the project capital cost. Absent this pertinent information, the application does not conform to Criterion (12).

Criterion (13c) *"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and … persons* [with disabilities]*, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

> *(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services*

NHAMC states, "The payor mix for outpatient surgical services and other (non-surgical) outpatient services also includes the payor mix of outpatients expected to shift from the Mission emergency department to NH Asheville's emergency department."[21] However, as previously described, it is unreasonable for NHAMC to assume that 10 percent of Mission's ED patients discharged to home or self-care and residing in zip codes 28806, 28803, 28715, 28704, 28742, and 28759 will be served at the proposed cancer-focused hospital ED.

As previously described, NHAMC will not have the means to actually treat the most common types of patients that present to an ED. NHAMC does not demonstrate that it will have cardiologists, neurologists, obstetricians, or orthopaedic physicians on its medical staff or taking call at the proposed ED. Thus, NHAMC will not have the means to treat patients presenting with chest pain, heart attack, stroke

[20] NHAMC application page 190
[21] NHAMC application page 140

symptoms, bone fractures, labor complications, etc. NHAMC's emergency physicians may only stabilize these patients and refer them to another acute care facility for treatment.

Therefore, the projected payor mix for ED services is unreasonable and the application does not conform to Criterion (13c).

Criterion (18a) *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Based on the facts which result in Novant Health being non-conforming with Criteria (1), (3), (4), (5), (6), and (13c), it should also be found non-conforming with Criterion (18a).

10A NCAC 14C .3803

The Novant Health application does not conform to 10A NCAC 14C .3803 because projected acute care bed utilization is not based on reasonable and adequately supported assumptions. See discussion regarding projected utilization in Criterion (3).

COMMENTS SPECIFIC TO MISSION HOSPITAL
PROJECT ID No. B-012518-24

Criterion (1) "*The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved*."

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Mission fails to conform with Criterion (1) and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and, thus, is not approvable.

Criterion (3) "*The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed*."

On application page 50 Mission states, "Mission has generated a bed need in the 2022 and 2024 SMFPs." Application page 91 states, "Mission is the only appropriate applicant that can meet the demand for the high acuity services that generated the need." However, no single hospital or system is entitled to the beds or entitled to receive priority status in a competitive review. All applicants are allowed to submit applications, and all qualified applicants must have their applications reviewed in accordance with the applicable need criteria and rules. Mission's interpretation would never allow a new entrant into the market dominated by one provider, which is not supported by the CON law.

On page 47 in Chapter 5 of the 2022 SMFP, it states: "Any person can apply to meet the need, not just the health service facility or facilities that generated the need."

In the 2022 Durham/Caswell acute care bed review, the Agency provided the following, "In Section C, pages 32-34, Duke states the need for 68 acute care beds in the Durham/Caswell multicounty service area was generated entirely by DUH. However, anyone may apply to meet the need, not just Duke."

In the 2021 Mecklenburg acute care bed review, the Agency stated the following, "In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states: "Any person can apply to meet the need, not just the health service facility or facilities that generated the need."

Neither the CON Statute nor the SMFP support any priority of need for services proposed among applicants in a competitive review. Doing so would unfairly tilt the competitive scales in the dominant provider's favor, which would harm patients and payors. It would also encourage the Agency to avoid analyzing applications according to their individual merit and would prevent it from conducting a reasonable comparative analysis. It would also eliminate any incentive a provider has to try to manage its capacity constraints. The Agency appropriately disregarded any priority toward Mission regarding the need for additional acute care beds in the 2022 Buncombe/Graham/Madison/Yancey Acute Care Bed Review.

On page 88 Mission states, "Using the 2024 SMFP need determination to add beds to the undeveloped AdventHealth Asheville or any other small new hospital applicant will not meet the urgent need for more beds at Mission driven by high acuity patients. Any new hospital will not be developed for several years and will not be able to offer the trauma, tertiary, and highly specialized services that Mission offers and residents of the region demand." However, Mission has the burden of demonstrating the need only for the services it proposes in its application. Mission's opinions regarding the need for additional acute care beds in community hospitals are irrelevant to AdventHealth Asheville's application and the Agency's evaluation of AdventHealth Asheville's application regarding Criterion (3).

Mission's application appears to take the position that there was a need determination specifically for high-acuity, acute care beds or that there is a greater need for high-acuity acute care beds. However, the need determination was simply for acute care beds, which are needed to serve residents of the Buncombe-Graham-Madison-Yancey County multicounty service area. The fact that smaller community hospitals have capacity indicates only that there is no projected additional need in those respective counties, not that a smaller community hospital cannot meet the need identified in Buncombe-Graham-Madison-Yancey multicounty service area. Additionally, any increase in acute care beds in the service area will alleviate capacity constraints at Mission, even if such beds are at a smaller community hospital in Buncombe County, by decreasing demand at Mission for the same services, thereby freeing up existing resources at Mission's main campus for higher acuity care, if needed.

The increasing demand for acute care beds in the service area is primarily due to population growth and aging rather than an elevated need for higher acuity care. As the population in the Buncombe/Graham/ Madison/Yancey multicounty service area continues to grow and age, so does the overall demand for healthcare services, including acute care beds.

AdventHealth, as well as many others as reflected in lawsuits and public statements about Mission's alleged capacity constraints, believes any capacity constraints at Mission are self-inflicted. Mission Health has shuttered physician practices throughout western North Carolina, which redirects patient admissions from its community hospitals to Mission Hospital. As shown in the following table, the outlying Mission Health hospitals provide a limited range of specialty services because Mission Health has not adequately staffed these facilities.

Specialty Services Available at Mission Health Facilities

Specialty Service	Transylvania	Angel Medical Center	Blue Ridge Regional	Mission McDowell	Highlands-Cashiers	Mission Hospital
Burn care	X	X	X	X	X	X
Cardiology	X	X	X	X	X	X
Emergency care	X	X	X	X	X	X
Imaging services	X	X	X	X	X	X
Infusion therapy	X	X		X		X
Mental health	X	X	X	X	X	X
Orthopedic care	X	X	X	X	X	X
OP Physical Rehabilitation	X	X	X	X	X	X
Surgery	X	X	X	X	X	X
Women's care (Breast health)	X	X	X	X	X	X
Wound care	X	X		X		X
Labor & Delivery						X
Urology						X
Neurology						X
Oncology						X
Endocrinology						X
Pediatrics						X

Source: Mission Health facility websites

Application page 74 states, "ED Admissions as a percentage of total Admissions have grown significantly." However, an Emergency Medicine physician with experience in the Mission Emergency Department has previously testified that HCA has excessively transferred patients from the EDs at the five Mission satellite hospitals. Formal complaints have been made to DHHS from Mission nurses regarding transferring emergency department patients to inpatient rooms. See AdventHealth Asheville Exhibit C.8-5. Mission has the ability to decompress its capacity constraints by redirecting patients back to HCA community hospitals in western North Carolina.

The approval of AdventHealth Asheville will effectively decompress capacity constraints at Mission by redirecting a portion of lower acuity patient volume from Mission to a convenient, community-based hospital setting.

Application page 41 references the approval of AdventHealth Asheville and how the decision has been appealed to the Court of Appeals. "Thus, Mission has not had any relief to address its high occupancy rates." However, Mission is appealing the AdventHealth Asheville decision; thus, Mission is holding up its own relief!

Application page 41 also indicates that Mission's 2024 utilization is so high that it has been approved for a temporary increase in bed capacity.[22] This kind of request is not unique to Mission, as many hospitals across the state regularly seek temporary bed capacity increases. In fact, some have made such requests continuously for many years. Mission's recent request resulted in approval for 73 additional beds, which is nearly three times the requested 26 additional acute care beds. Therefore, the status quo is a more effective alternative for expanding capacity at Mission than the proposed project.

Application page 49 claims that the growing demand for high acuity services within the service area has resulted in more admissions and a longer average length of stay (ALOS). However, this trend is not unique to Mission Hospital, nor is it solely attributable to high acuity services. Hospitals both large and small are experiencing increasing admissions and longer ALOS. The following table shows acute care admissions at AdventHealth Hendersonville increased 7.6 percent from FY2019 to FY2023 and patient days grew more than two times the admission rate at 18.2 percent.

AdventHealth Hendersonville

	FY2019	FY2023	% Change
Admissions	3,288	3,537	7.6%
Days of Care	11,398	13,467	18.2%
ALOS	3.47	3.81	

Source: LRAs

Application page 77 cites an increasing trend of trauma volume at Mission, which "highlights critical need for Mission to have bed capacity to meet this demand." However, an Emergency Medicine physician with experience in the Mission Emergency Department has previously testified that Mission is responsible for medically unnecessary trauma alerts. In one instance, the physician (and former assistant director of Mission's ED) described an incident in which an 82-year-old patient, who had other medical problems, arrived by ambulance with a scrape on his head, and a trauma alert was needlessly activated. In another unwarranted trauma alert, a 79-year-old patient arrived after a car accident, but had no injuries.[23] Copies of the complaint and additional documentation are publicly available.[24]

Criterion (4) "*Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed*."

The Mission application does not conform to all other applicable statutory and regulatory review criteria and, thus, is not approvable. An application that cannot be approved cannot be an effective alternative. See discussion regarding Criteria (1), (18a), and (20).

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[22] Per § 131E-83 Temporary change of hospital bed capacity: A hospital may temporarily increase its bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the hospital notifies and obtains the approval of the Division of Health Service Regulation.

[23] https://www.northcarolinahealthnews.org/2023/06/19/doctors-lawsuit-hca-healthcare-teamhealth-overcharged-patients/

[24] https://drive.google.com/drive/folders/10kt9G1l4M7l3bdbCNZkQm-vB0chH61ks

Mission's request for a temporary bed increase granted 73 additional beds, which is nearly three times the requested 26 additional acute care beds. Therefore, the status quo is a more effective alternative for expanding capacity at Mission than the proposed project.

On application page 108, Mission claims its alternative of building a separate 26-bed freestanding hospital in Buncombe County was rejected, partly because it would require moving an OR, which is not true. Mission could have pursued the alternative and been a qualified applicant without moving an OR. Mission could have developed procedure rooms for the provision of surgical services. Procedure rooms do not require a need determination.

Criterion (18a) *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Mission Hospital currently controls 100 percent of the acute care beds in the identified service area. Mission proposes to extend its market dominance in western North Carolina.

AdventHealth Asheville is approved to develop a new acute care hospital with 67 acute care beds in Buncombe County (CON Project I.D. B-12233-22). The project is under appeal by Mission.

If Mission's application is approved, Mission will control 92.3 percent of the existing and approved acute care beds in the Buncombe/Graham/Madison/Yancey multicounty service area. If AdventHealth Asheville's application is approved, AdventHealth Asheville will control 11.6 percent of the existing and approved acute care beds in the Buncombe/Graham/Madison/Yancey multicounty service area.

Therefore, with regard to patient access to a new or alternate provider, the application submitted by AdventHealth Asheville is the more effective alternative, and the application submitted by Mission is the less effective alternative.

Furthermore, the Mission application cannot be found conforming to Criterion (18a) because it does not conform to Criterion (20). Mission fails to demonstrate that it has provided quality care in the past; thus, it cannot have a positive impact on quality.

Mission has been sued by the state of North Carolina, sued by Buncombe County, sued by two of its emergency physicians, and placed in "immediate jeopardy" by the U.S. Centers for Medicare & Medicaid Services. Even after it initially responded to the findings that placed it in immediate jeopardy, Mission was found in a follow-up survey to have been non-compliant with numerous Medicare regulations as discussed below.

- In August 2021, a class-action lawsuit was filed in North Carolina state court against HCA Healthcare and Mission Health, alleging anti-competitive practices violating the North Carolina Constitution and antitrust and consumer protection laws.

- In June 2022, the city of Brevard (Transylvania County) filed a lawsuit against HCA alleging that the hospital operator engaged in an "anti-competitive scheme involving the illegal maintenance and enhancement of monopoly power" in the acute care hospital and outpatient care markets in seven counties in North Carolina. Transylvania Regional Hospital is in Brevard, the county's seat, and is one of five hospitals in Western North Carolina owned by HCA Healthcare and in the Mission Health regional system.[25]
- On July 27, 2022, Buncombe County and the city of Asheville filed a joint class-action antitrust lawsuit against HCA Healthcare and Mission Health, alleging an "extensive pattern of alleged behavior by HCA intended to monopolize healthcare markets in western North Carolina, the result of which is artificially high prices for healthcare services and a reduced standard of care that has damaged, and continues to damage, local governments and private entities who act as self-insurers for their employees."
- In December 2023, Attorney General Josh Stein filed a lawsuit against several HCA/Mission entities for failing to comply with the Asset Purchase Agreement executed by one of the entities when it purchased Mission Health System in 2019. Attorney General Stein alleges that HCA is not providing the quality, consistent emergency, and cancer care for western North Carolinians it committed to deliver. When HCA purchased Mission, Attorney General Stein negotiated additional healthcare protections for patients because he was concerned that HCA would cut critical services that the community needs. HCA promised not to discontinue emergency and trauma services or oncology services at Mission Hospital until at least 2029. However, over the last several years, the North Carolina Department of Justice has heard from hundreds of North Carolinians about the issues at HCA and received more than 500 complaints. Patients specifically have raised concerns about emergency and trauma services and oncology services. A fact sheet on the lawsuit is included in the AdventHealth Asheville application, Exhibit C.8-3.

According to a draft report by Mark Hall, Director of the Health Law and Policy Program at Wake Forest University, Staff cuts have driven up patient-care profits at Mission Hospital in Asheville after HCA Healthcare acquired Mission. The report cites that HCA reduced patient-care costs by cutting the patient-care staffing rate from 6.0 full-time equivalent staff per occupied bed in 2018 to 3.7 in 2021. Meanwhile, average staffing at other North Carolina hospitals maintained at 5.1 per patient. A copy of the report is included in Attachment 5.

Mission's patient experience ratings have plummeted in recent years. The Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. Each year HCAHPS administers several hundred randomly selected patients at each hospital. One of the HCAHPS survey's key summary measures is simply whether the patient would recommend the hospital to others. The percentage responding no vs. yes is converted to a scale from one star (worst) to five stars (best). From 2014-2018, Mission Hospital averaged four stars. In 2019, however, the first year under HCA, this patient rating (along with others shown in the following Figure) dropped to two stars, and remained there, until 2022, when it dropped to one star.

A one-star rating places Mission Hospital in the bottom 3.6 percent of hospitals nationally on whether its patients would recommend the hospital to others. No other NC hospital with more than 300 beds was

[25] Jones, Andrew. " HCA, Mission hit with 2nd WNC antitrust suit in a year, this one from a Transylvania city." Asheville Citizen Times, 6 June 2022. https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/

rated this low in 2022.[26] Without the pressure of competing providers, a monopolistic hospital may not prioritize maintaining high standards of care, leading to potential decreases in the quality of services offered. Unfortunately, Mission Hospital's low HCAHPS patient satisfaction scores reflect this issue.

In a historic move, elected officials, doctors, and others have formed a group with the goal of compelling the sale of Mission Health by HCA Healthcare. Reclaim Health WNC is a volunteer-led grassroots organization founded by N.C. state Sen. Julie Mayfield. Reclaim Health WNC states that it is a voice for the physicians, nurses, and staff who work at or with Mission who are not able to speak out due to the culture of fear and retaliation that HCA has created. Organizers of Reclaim Health WNC include:

- Dr. Clay Ballantine
- Brevard Mayor Maureen Copelof
- Coalition of Asheville Neighborhoods President Rick Freeman
- Nurse Nansi Gregor-Holt
- The Rev. Missy Harris
- Victoria Hicks, Health Equity Coalition member
- Dr. Scott Joslin
- Dr. Bruce Kelly
- Dr. Robert Kline
- Dr. Allen Lalor
- Geri Legeay
- Steve Legeay
- N.C. state Sen. Julie Mayfield
- Dr. Mike Messino
- John Nicolay
- Nurse and patient advocate Karen Sanders
- Former Western Carolina Medical Society Director Miriam Schwarz
- Highlands Mayor Patrick Taylor

The goals of the group are to replace HCA with a nonprofit owner "committed to meeting the healthcare needs of the people of WNC," as well as "holding HCA accountable for their harmful culture and practices," and restoring best in class care for the system, leaders said.[27] See also Attachment 5.

Based on this publicly available information, it could not be more evident that Mission's proposal to expand its licensed bed capacity to include 26 additional acute care beds cannot positively impact competition in the service area.

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[26] Hall, M., JD. (2024). Mission Hospital's Quality Ratings Following HCA's Acquisition. Wake Forest University. https://hlp.law.wfu.edu/wp-content/uploads/sites/11/2024/02/HCA-Mission-Quality-Ratings-working-draft-WFU-1.pdf

[27] Burgess, B. (2024, July 25) Historic move: new group says HCA must sell Mission, Western NC's main health care system. Asheville Citizen Times. https://www.citizen-times.com/story/news/local/2024/07/25/new-group-hca-must-sell-mission-western-ncs-main-health-care-system/74528640007/

Criterion 20 *"An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past."*

Mission Hospital and the Mission Health community hospitals have an established pattern of failure to provide quality care in the past.

The time period identified in the application form for evaluation of Criterion 20 is 18-months from the date of submission of the application. Section O.4 of the CON application requires the applicant to "Document that the health service facilities identified in Form O have provided quality care during the 18 months immediately preceding submission of the application (18-month look-back period)."

Form O (pg. 168) identifies six (6) hospitals that are owed by HCA Healthcare, Inc., which is a related entity. The hospitals include McDowell Hospital, Angel Medical Center, Highlands-Cashiers Hospital, Blue Ridge Regional Hospital, and Transylvania Regional Hospital.

Transylvania Regional Hospital failed to meet all Medicare Conditions of Participation based on a 17 March 2023 survey. Blue Ridge Regional Hospital failed to meet all Medicare Conditions of Participation based on a 13 July 2023 survey. See Attachment 3.

Most significantly, a complaint investigation was conducted at Mission Hospital from November 13, 2023 through December 9, 2023. This investigation resulted in the identification of Immediate Jeopardy on December 1, 2023 on Mission Hospital was informed by the U.S. Centers for Medicare & Medicaid Services that it is in "immediate jeopardy" related to deficiencies in care.

According to CMS regulations, Immediate Jeopardy (IJ) represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death. These situations must be accurately identified by surveyors, thoroughly investigated, and resolved by the entity as quickly as possible. In addition, noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for providers, suppliers, or laboratories (entities). An immediate jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

CMS determined the hospital nursing staff failed to provide a safe environment for patients presenting to the ED by failing to accept patients on arrival, resulting in lack of or delays with triage, assessments, monitoring, and implementation of orders, including labs and telemetry. ED nursing staff failed to assess, monitor, and evaluate patients to identify and respond to changes in patient conditions. The hospital staff failed to ensure qualified staff were available to provide care and treatment for patients who arrived in the ED. The cumulative effects of these practices resulted in an unsafe environment for ED patients. At least three patients died, and others were endangered at Mission Hospital following significant delays and lapses of care in the emergency department and other areas.

Nurses had sent formal complaints to the North Carolina Department of Health and Human Services since early 2022, some about transfer procedures in the hospital's emergency department that they contended

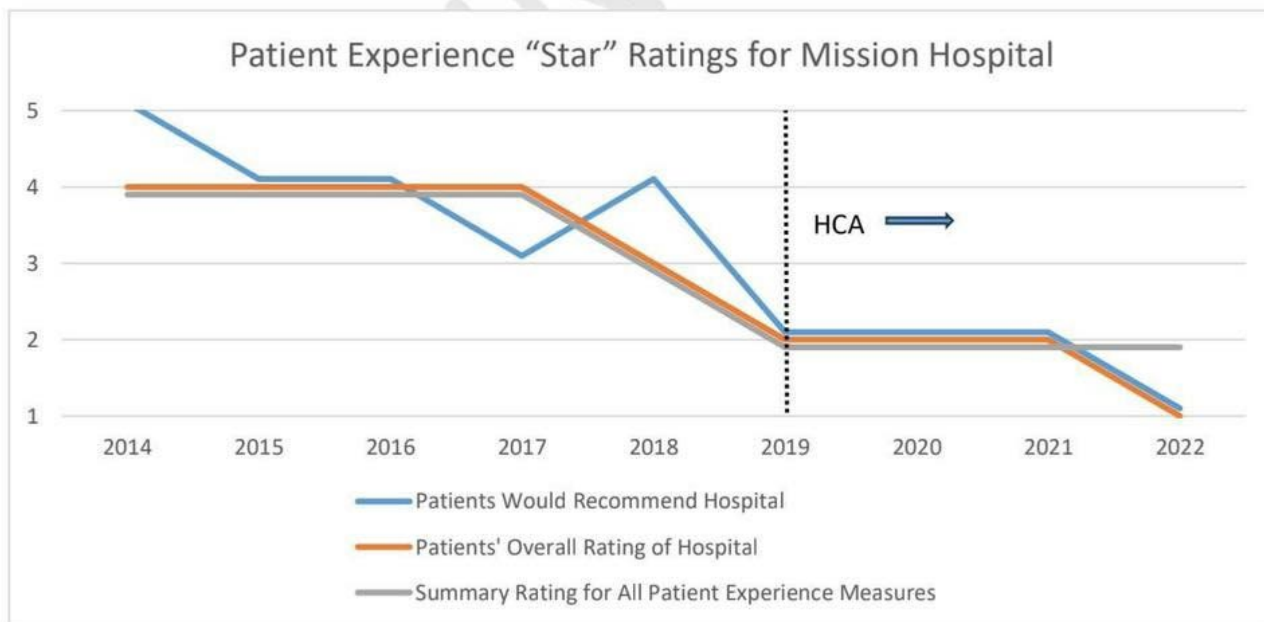
endangered patients.[28] A copy of one of the letters is included in the AdventHealth Asheville application, Exhibit C.8-5. At that time, NCDHHS had not visited the hospital, citing its own staff shortages.

In the 2011 Wake County Nursing Facility Review, the Agency found three CON applications non-conforming to Criterion 20 because a facility owned by the applicant or related entity had certification deficiencies constituting substandard quality of care during the 18 months immediately preceding the date of the Agency's decision. See Attachment 4.

In its analysis of Criterion 20 for Liberty-Garner (J-8723-11), Liberty-Morrisville (J-8726-11), and Liberty-North Raleigh (J-8727-11) in the 2011 Wake County Nursing Facility Review the Agency states, "the applicants provide a list of nursing facilities they own or operate in North Carolina, including Capital Nursing and Rehabilitation Center in Raleigh. Capital Nursing and Rehabilitation Center is an existing nursing facility in Wake County with 125 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, Capital Nursing and Rehabilitation Center had certification deficiencies constituting substandard quality of care, including immediate jeopardy to resident health or safety. Therefore, the application is not conforming to this criterion." See Attachment 4 for excerpts from the 2011 Agency Findings.

Consistent with the Agency's application of Criterion 20 in the 2011 Wake County Nursing Facility Review, the Agency should find Mission nonconforming with Criterion 20 in this 2024 acute care bed review.
As previously described, Mission's patient experience ratings have plummeted in recent years. One of the HCAHPS survey's key summary measures is simply whether the patient would recommend the hospital to others. The percentage responding no vs. yes is converted to a scale from one star (worst) to five stars (best). From 2014-2018, Mission Hospital averaged four stars. In 2019, however, the first year under HCA, this patient rating (along with others shown in the following Figure) dropped to two stars, and remained there, until 2022, when it dropped to one star.

[28] Jones, Andrew. Mission patients endangered by emergency department transfer procedures, nurses say. Asheville Watchdog. 24 August 2023 https://avlwatchdog.org/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/



A one-star rating puts Mission Hospital in the lowest 3.6 percent of hospitals nationwide in terms of patient recommendations. In 2022, no other hospital in North Carolina with over 300 beds received such a low rating. [29] Without the pressure from competing providers, a market dominant hospital might not prioritize maintaining high standards of care, potentially leading to a decline in service quality. Unfortunately, the low HCAHPS patient satisfaction scores at Mission Hospital highlight this problem

The issues identified by CMS are further corroborated by the voices of Mission's own staff. Nurses and other healthcare professionals have raised alarms about dangerous practices and staffing shortages, which have not been adequately addressed by the hospital administration.

Since early 2022, nurses have sent formal complaints to the North Carolina Department of Health and Human Services regarding unsafe transfer procedures in the ED, which they argue endanger patient safety. This persistent concern indicates a culture of negligence and inadequate response from hospital leadership.

The failure of NCDHHS to conduct timely inspections due to staff shortages does not absolve the hospital of responsibility; rather, it emphasizes the need for internal accountability and proactive quality assurance measures.

In January 2023, registered nurses at Mission Hospital staged protests to demand safe staffing levels, emphasizing that current conditions jeopardize both patients and staff. [30]

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[29] Hall, M., JD. (2024). Mission Hospital's Quality Ratings Following HCA's Acquisition. Wake Forest University. https://hlp.law.wfu.edu/wp-content/uploads/sites/11/2024/02/HCA-Mission-Quality-Ratings-working-draft-WFU-1.pdf

[30] Santostasi, Stephanie. "Nurses rally outside Mission to again push for safe staffing on National Day of Action." WLOS ABC 13 https://wlos.com/news/local/nurses-rally-outside-mission-hospital-again-push-for-safe-staffing-

Subsequent rallies in April 2023 further underscored issues such as increased workplace violence, broken equipment, and insufficient staffing—factors that contribute directly to compromised patient care. [31]

As of July 2024, nurses are considering a strike to push for "safe staffing" protocols, demonstrating the ongoing and unresolved nature of these issues. [32]

Given the comprehensive evidence of regulatory noncompliance, staff concerns, declining patient satisfaction, and historical precedents, Mission Hospital and its affiliates demonstrate a consistent pattern of failing to provide quality care. This pattern is not only detrimental to patient safety but also undermines the credibility and trust that patients and the community place in these healthcare institutions.

In alignment with the Agency's previous findings in the 2011 Wake County Review, the 2024 application for Mission Hospital should be deemed nonconforming with Criterion (20).

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understaffed-dangerous-national-day-of-action-united-national-attention-nightly-news-lester-holt-emergency-department

[31] (2023, April 10). Mission Hospital nurses to hold a rally over HCA's failure to protect patients and nurses from assaults and other unsafe working conditions. Https://www.Nationalnursesunited.org/. Retrieved May 21, 2024, from https://www.nationalnursesunited.org/press/mission-hospital-nurses-to-hold-rally-over-hca-failure-to-protect-patients-and-nurses

[32] https://carolinapublicpress.org/64159/nurses-mission-health-hospital-union-rally-asheville-nc/

COMPARATIVE ANALYSIS OF THE COMPETING ACUTE CARE BED APPLICATIONS

The following factors are suggested for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Competition (Access to a New or Alternate Provider)
- Scope of Services
- Geographic Accessibility (Location within the Service Area)
- Access by Service Area Residents
- Historical Utilization
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Projected Average Net Revenue per Patient
- Projected Average Total Operating Cost per Patient

According to documentation used by the Agency for competitive reviews, “quality of care” may also be considered. See Attachment 6. Given the quality of care concerns that already exist in the service area, the Agency should include “quality of care” as a comparative factor in this review.

The following pages summarize the competing applications relative to the potential comparative factors.

Conformity to CON Review Criteria

Three CON applications have been submitted to develop acute care beds in the Buncombe, Graham, Madison, and Yancey county acute care service area. The applicants each propose to develop 26 acute care beds. Based on the 2024 SMFP’s need determination, only 26 acute care beds can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by AdventHealth Asheville demonstrates conformity to all Statutory and Regulatory Review Criteria.

Conformity of Applicants

Applicant	Project I.D.	Conforming/ Non-Conforming
Mission Hospital	B-12518-24	No
AdventHealth Asheville	B-12526-24	**Yes**
Novant Health Asheville Medical Center	B-12520-24	No

The AdventHealth Asheville application is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed separately in this document, the competing applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, the AdventHealth Asheville application is the **most effective** alternative regarding conformity with applicable review Criteria.

Competition (Patient Access to a New or Alternative Provider)

In previous competitive batch reviews, the Agency has encapsulated this comparative factor by stating, "generally, the application proposing to increase competition in the service area is the more effective alternative regarding this comparative factor." However, this summation does not adequately convey the import and weight of this comparative factor in this acute care bed review.

Since 1995, Mission has operated as the sole hospital provider in Buncombe County. After the not-for-profit health care system was sold to for-profit HCA Healthcare in 2018. Mission is now a for-profit hospital provider that maintains an exclusive market position without state oversight over its rates, physician employment, maintenance of services, or health plan contracting practices.[33] Additional events have highlighted the great need for hospital competition in Buncombe County. Mission has closed numerous physician clinics, dozens of providers have left Buncombe County, and Mission nurses have unionized. In August 2021, North Carolina patients filed a class-action lawsuit against HCA Healthcare and Mission Health, alleging anti-competitive practices violating the North Carolina Constitution and antitrust and consumer protection laws.
In June 2022, the city of Brevard (Transylvania County) filed a lawsuit against HCA, alleging that the hospital operator engaged in an "anti-competitive scheme involving the illegal maintenance and enhancement of monopoly power" in the acute care hospital and outpatient care markets in seven counties in North Carolina.[34]

In July 2022, Buncombe County and the city of Asheville filed a joint class-action antitrust lawsuit against HCA Healthcare and Mission Health, alleging an "extensive pattern of alleged behavior by HCA intended to monopolize healthcare markets in western North Carolina, the result of which is artificially high prices for healthcare services and a reduced standard of care that has damaged, and continues to damage, local governments and private entities who act as self-insurers for their employees." See Exhibit C.8-2, B-12526-24.

On January 26, 2023, registered nurses from Mission Hospital rallied outside the hospital to call for safe staffing levels as the nurses rallying said the issue of Mission continuing to be understaffed is putting both patients and staff in danger.[35]

On April 10, 2023, registered nurses from Mission Hospital rallied again outside the hospital to highlight their patient safety concerns, including increased incidents of workplace violence, broken hospital equipment, and unsafe staffing levels.[36]

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[33] Fuse Brown E. "To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law." New York: Milbank Memorial Fund, January 2019. https://www.milbank.org/wp-content/uploads/2019/01/MMF-North Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf.

[34] Jones, Andrew. " HCA, Mission hit with 2nd WNC antitrust suit in a year, this one from a Transylvania city." Asheville Citizen Times, 6 June 2022. https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/

[35] Santostasi, Stephanie. "Nurses rally outside Mission to again push for safe staffing on National Day of Action." WLOS ABC 13 https://wlos.com/news/local/nurses-rally-outside-mission-hospital-again-push-for-safe-staffing-understaffed-dangerous national-day-of-action-united-national-attention-nightly-news-lester-holt-emergency-department

[36] (2023, April 10). Mission Hospital nurses to hold a rally over HCA's failure to protect patients and nurses from assaults and other unsafe working conditions. Https://www.Nationalnursesunited.org/. Retrieved May 21, 2024, from

In December 2023, Attorney General Josh Stein filed a lawsuit against several HCA/Mission entities for failing to comply with the Asset Purchase Agreement executed by one of the entities when it purchased Mission Health System in 2019. Attorney General Stein alleges that HCA is not providing the quality, consistent emergency, and cancer care for western North Carolinians it committed to deliver. When HCA purchased Mission, Attorney General Stein negotiated additional healthcare protections for patients because he was concerned that HCA would cut critical services that the community needs. HCA promised not to discontinue emergency and trauma services or oncology services at Mission Hospital until at least 2029. However, over the last several years, the North Carolina Department of Justice has heard from hundreds of North Carolinians about the issues at HCA and received more than 500 complaints. Patients specifically have raised concerns about emergency and trauma services and oncology services. A fact sheet on the lawsuit is included in Exhibit C.8-3, B-12526-24.

Numerous incidents occurred at Mission Hospital between April 2022 and November 2023 that resulted in Mission Hospital being informed by the U.S. Centers for Medicare & Medicaid Services that it was in "immediate jeopardy" related to deficiencies in care. According to CMS regulations, Immediate Jeopardy (IJ) represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death. These situations must be accurately identified by surveyors, thoroughly investigated, and resolved by the entity as quickly as possible. In addition, noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for providers, suppliers, or laboratories. An immediate jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm. CMS determined the hospital nursing staff failed to provide a safe environment for patients presenting to the ED by failing to accept patients on arrival, resulting in lack of or delays with triage, assessments, monitoring, and implementation of orders, including labs and telemetry. ED nursing staff failed to assess, monitor, and evaluate patients to identify and respond to changes in patient conditions. The hospital staff failed to ensure qualified staff were available to provide care and treatment for patients who arrived in the ED. The cumulative effects of these practices resulted in an unsafe environment for ED patients. At least three patients died, and others were endangered at Mission Hospital in 2022 and 2023 following significant delays and lapses of care in the emergency department and other areas. See Exhibit C.8-4, B-12526-24 and Attachment 1 to these comments. Even after Mission responded to the allegations of immediate jeopardy, after an unannounced Revisit Survey that took place between February 20, 2024 and February 23, 2024, Mission was still found to be out of compliance with various Medicare Conditions of Participation, including those set forth in 42 CFR 482.12 (Governing Body); 482.13 (Patient's Rights), 482.21 (Quality Assessment and Performance Improvement), 482.23 (Nursing Services), 482.27 (Laboratory Services) and 482.55 (Emergency Services). See Attachment 2.

Mission Hospital's patient experience ratings have significantly declined in recent years. According to The Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey, which measures patients' perspectives on hospital care, the hospital's rating dropped from an average of four stars between 2014 and 2018 to two stars in 2019, the first year under HCA management. The rating remained at two stars until 2022, when it further fell to one star, placing the hospital in the bottom 3.6 percent

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https://www.nationalnursesunited.org/press/mission-hospital-nurses-to-hold-rally-over-hca-failure-to-protect-patients-and nurses

nationally for patient recommendations.[37] This decline is particularly notable as no other North Carolina hospital with over 300 beds had such a low rating in 2022. Without the pressure of competing providers, a monopolistic hospital may not prioritize maintaining high standards, leading to the decrease in the quality of services offered.

In a historic move, elected officials, doctors, and others have formed a group with the goal of compelling the sale of Mission Health by HCA Healthcare. Reclaim Health WNC is a volunteer-led grassroots organization founded by N.C. state Sen. Julie Mayfield. Reclaim Health WNC states that it is a voice for the physicians, nurses, and staff who work at or with Mission who are not able to speak out due to the culture of fear and retaliation that HCA has created. The goals of the group are to replace HCA with a nonprofit owner "committed to meeting the healthcare needs of the people of WNC," as well as "holding HCA accountable for their harmful culture and practices," and restoring best in class care for the system, leaders said.[38]

Based on the previously described history of events in Buncombe County and at Mission in particular, it could not be more evident that Mission's proposal to expand its dominant market position to include 26 additional acute care beds cannot be an effective alternative in this CON review.

As between the applications submitted by AdventHealth Asheville and Novant Health, the Agency must assess which proposal most effectively promotes competition via patient access to a new or alternative provider. NHAMC states that it will be a "cancer and surgery-focused community hospital in Buncombe County….two cancer-focused physician practices, Messino Cancer Centers ("MCC"), and NH Surgical Partners – Biltmore ("NHSPB"), support this project and will treat the majority of their patients at NH Asheville."[39] NHAMC's methodology for projecting inpatient days of care is based "only on these physicians' commitments."[40] Therefore, **the extent to which the NHAMC proposal will enhance competition in the service area is extremely limited**.

In stark contrast, AdventHealth Asheville will be a full-service hospital offering an array of services that NHAMC will not, including maternity, cardiology, neurology, and orthopaedics.

More importantly, AdventHealth sought input and direction from the very people that its new hospital will serve in the area. AdventHealth's local representatives visited the entire acute care service area. AdventHealth's team personally visited leaders in Buncombe, Graham, Madison, and Yancey Counties to learn more about each community's unique health care needs. Conversations in town halls, county courthouses, schools, colleges, and fire departments offered profound insight into the public's desire for additional healthcare choice and competition in Western North Carolina.

Since April 2024, AdventHealth's representatives traveled over 2,000 miles in Buncombe, Graham, Madison, and Yancey Counties to meet with residents and better understand their unique community

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[37] Hall, M., JD. (2024). Mission Hospital's Quality Ratings Following HCA's Acquisition. Wake Forest University. https://hlp.law.wfu.edu/wp-content/uploads/sites/11/2024/02/HCA-Mission-Quality-Ratings-working-draft-WFU-1.pdf

[38] Burgess, B. (2024, July 25) Historic move: new group says HCA must sell Mission, Western NC's main health care system. Asheville Citizen Times. https://www.citizen-times.com/story/news/local/2024/07/25/new-group-hca-must-sell-mission-western-ncs-main-health-care-system/74528640007/

[39] NHAMC application page 162

[40] ibid

healthcare needs. **AdventHealth visited every zip code and municipality within the service area.** More specifically, AdventHealth connected with every county commission, sheriff, health department, federally qualified health center (FQHC), public school system, community college, EMS agency, chamber of commerce, emergency management department and economic development organization. AdventHealth's team also met with numerous fire departments, senior centers, transit agencies and safety net non-profit organizations. Exhibit C.8-6, B-12526-24 includes documentation of AdventHealth's outreach throughout the service area.

Through its community outreach, AdventHealth gained valuable insights into the healthcare needs of the service area. The team was both humbled and honored by the community's overwhelming support for its proposal to add 26 beds to its new hospital in Weaverville. Attendees of AdventHealth's listening sessions, representing diverse ages and backgrounds, consistently expressed fear and frustration with the current healthcare situation, particularly in Buncombe County. Many individuals from Madison and Yancey Counties shared that they now seek care in neighboring Tennessee. Longtime residents highlighted the perceived contrast of what healthcare had been in the past compared to what it is now—citing long waits, poor experiences, and diminished quality.

The application submitted by Novant Health essentially proposes developing a new micro-hospital with only 26 acute care beds. However, a hospital with only 26 beds is a less effective alternative. A smaller hospital can accommodate fewer patients, especially during peak times, emergencies, or when demand spikes. Larger hospitals can offer a wider range of specialized services and facilities, including dedicated units for intensive care, maternity, surgery, and other medical needs, which a 26-bed hospital may lack or have limited capacity for. Moreover, a hospital dedicated to one specialty will end up sending most of its patients in need of emergency services to another hospital. Simple logic indicates that this separates the bed need from the hospital developing an emergency room.

In contrast, AdventHealth Asheville's proposal will benefit from economies of scale, operating more efficiently and cost-effectively by spreading fixed costs over a larger patient base, reducing per-patient costs. A larger hospital would offer significant advantages in terms of capacity, range of services, resource availability, operational efficiency, patient outcomes, and emergency preparedness, making them more effective in meeting community healthcare needs and thereby enhancing competition. AdventHealth Asheville will offer the same services that NHAMC proposes *in addition* to numerous other specialty services, e.g., cardiology, obstetrics, orthopaedics, etc.

For these reasons, AdventHealth Asheville is the **most effective alternative** for improving competition and establishing access to an alternative provider in the Buncombe, Graham, Madison, and Yancey multicounty service area.

Scope of Services

The Agency has previously stated in its written findings for acute care bed reviews that the application proposing to provide the greatest scope of services is the more effective alternative with regard to this comparative factor.

Mission Hospital is an existing acute care hospital which is a Level I trauma center, tertiary, and quaternary care referral medical center. As Mission's 2024 application is not approvable because it does not conform

to multiple statutory review criteria, the Agency can and should compare the scope of services between AdventHealth Asheville and NHAMC.

AdventHealth Asheville proposes to add 26 acute care beds to its approved new acute care hospital that will provide a broad array of specialty services, including but not limited to cardiothoracic, general surgery, neurosurgery, OB/GYN, oncology, ophthalmology, oral/dental, orthopedics, otolaryngology, plastic surgery, podiatry, urology, and vascular surgery. Novant proposes to offer only a narrow subset of AdventHealth Asheville's acute care services.

NHAMC proposes to establish a cancer-focused hospital that will provide a "limited range" of acute care services."[41] NHAMC's projected utilization is specifically based upon MCC's and NHSPB's historical patient utilization, which are primarily cancer patients. **NHAMC does not provide any data to support a scope of acute care services beyond cancer care**. This is a critical detail because it limits NHAMC's ability to enhance access and competition in the market.

NHAMC will not offer the following services: cardiology, neurology, orthopedics, labor and delivery, pediatrics, and ophthalmology. Therefore, NHAMC's project will not enhance access for patients needing these services. As a full-service hospital, AdventHealth Asheville will provide acute care services across a broad range of specialties effectively enhancing access for patients that require inpatient care.

AdventHealth proposes a broader scope of services than the NHAMC application. Therefore, AdventHealth Asheville is the **more effective** alternative concerning this comparative factor and NHAMC is the least effective alternative regarding scope of services.

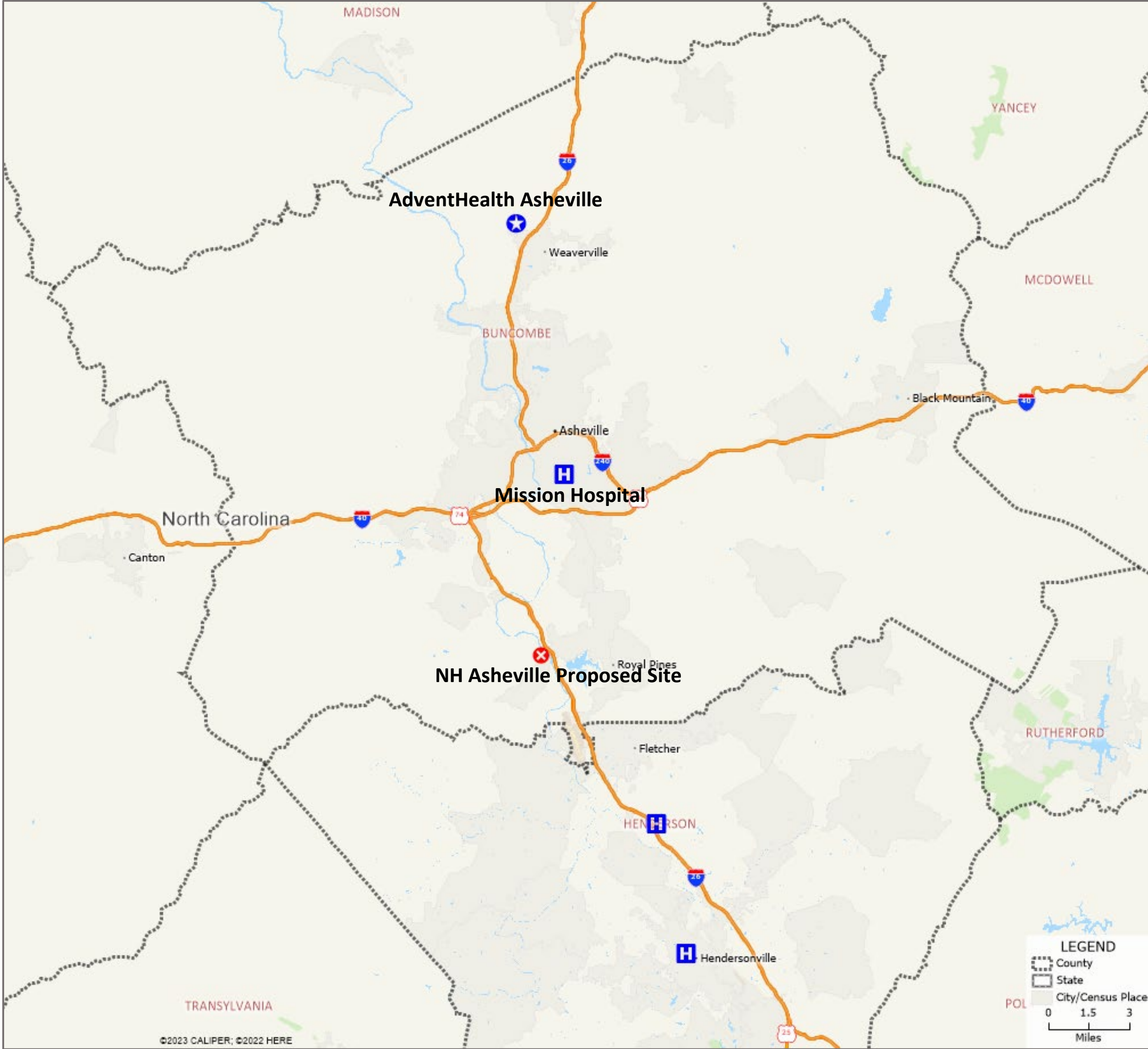
Geographic Accessibility

There are 733 existing licensed acute care beds, which are all located in Asheville (Buncombe County) at Mission Hospital. Mission proposes to develop 26 additional acute care beds at its existing hospital facility. Mission's proposal will not improve geographic accessibility because it will further saturate the concentration of acute care beds in downtown Asheville.

Novant Health proposes to develop a new acute care hospital located at 455 Long Shoals Drive in Arden. Novant Health's proposed site will not improve geographic access because it will be located in an area that is already serviced by AdventHealth Hendersonville and UNC Pardee. The following map shows the proposed facility locations in this competitive batch review.

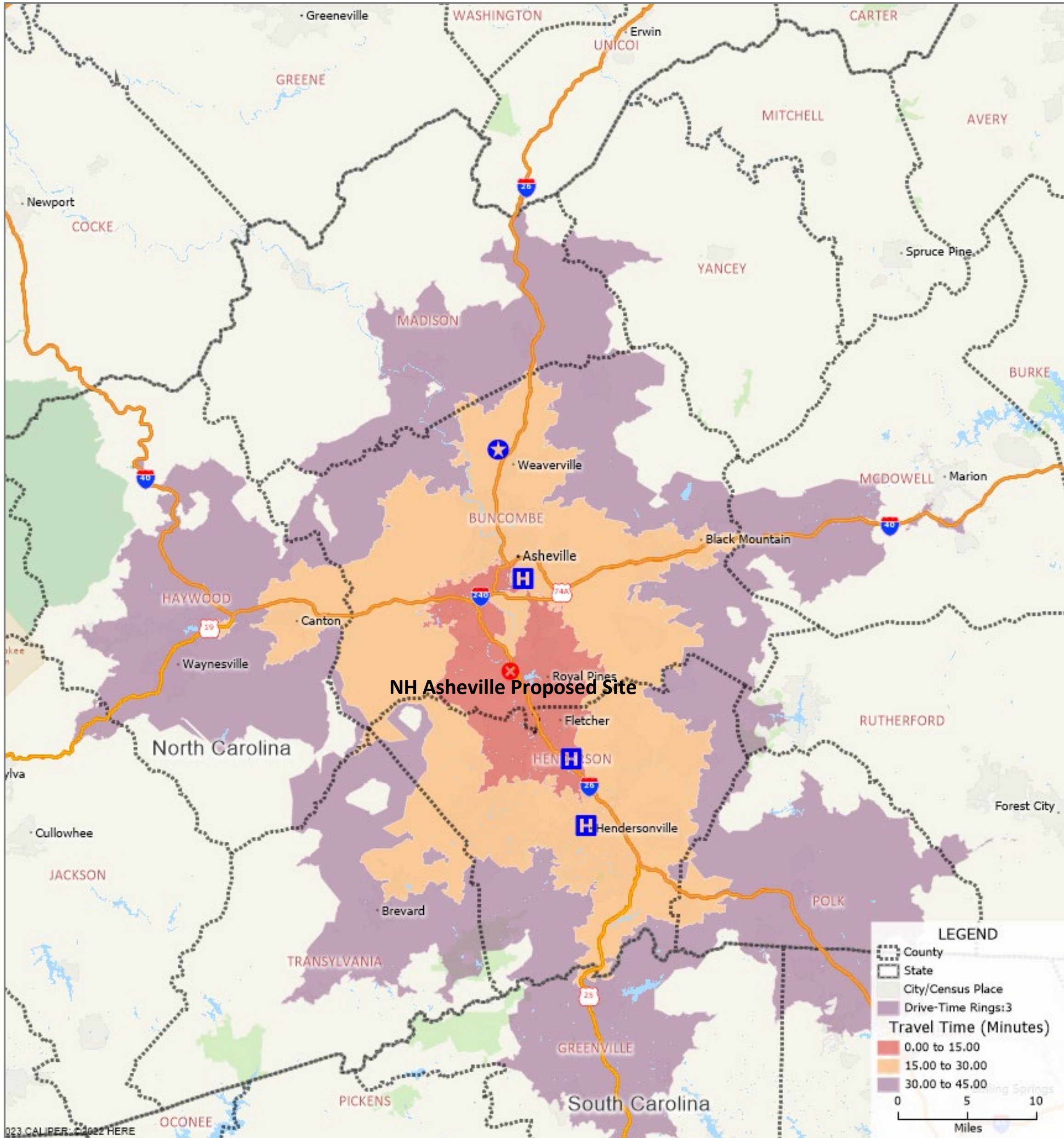
[41] NHAMC application page 36

Facility Locations for 2024 Acute Care Bed Review



NHAMC's proposed location is less than three miles from the Henderson County line. NHAMC will be more accessible for residents of Henderson County, which is not in the acute care service area, than it will be for residents of Madison and Yancey County. The following map illustrates drive times in three 15-minutes increments from NHAMC's proposed location in southern Buncombe County.

NHAMC Proposed Site and Approximate Drive Times



Source: Maptitude

As the previous map illustrates, Madison and Yancey County residents will have to travel significant distances to receive the limited scope of proposed services at NHAMC. Residents of Micaville in Yancey County will have to travel approximately 50 miles (54 minutes) to NHAMC. Residents of Hot Springs in Madison County will have to travel 45.2 miles (54 minutes) to NHAMC. As the following tables

demonstrate, AdventHealth Asheville will provide more favorable geographic access for residents of Madison and Yancey counties than NHAMC.[42]

Driving Distances from Madison & Yancey County to Novant Health Asheville Medical Center

	Madison Co.			Yancey Co.		Graham Co.	
	Marshall	**Mars Hill**	**Hot Springs**	**Burnsville**	**Micaville**	**Robbinsville**	**Fontana Dam**
Miles	29.6	28.5	45.2	45.6	50.8	94.5	96.2
Minutes	35	30	54	48	54	1 hr, 45	1 hr, 48 mins

Source: Google Maps

Driving Distances from Madison & Yancey County to AdventHealth Asheville

	Madison Co.			Yancey Co.		Graham Co.	
	Marshall	**Mars Hill**	**Hot Springs**	**Burnsville**	**Micaville**	**Robbinsville**	**Fontana Dam**
Miles	10.3	10.0	25.9	27.1	32.3	97.5	99.2
Minutes	16	13	37	32	38	1 hr, 56 mins	1 hr, 55 mins

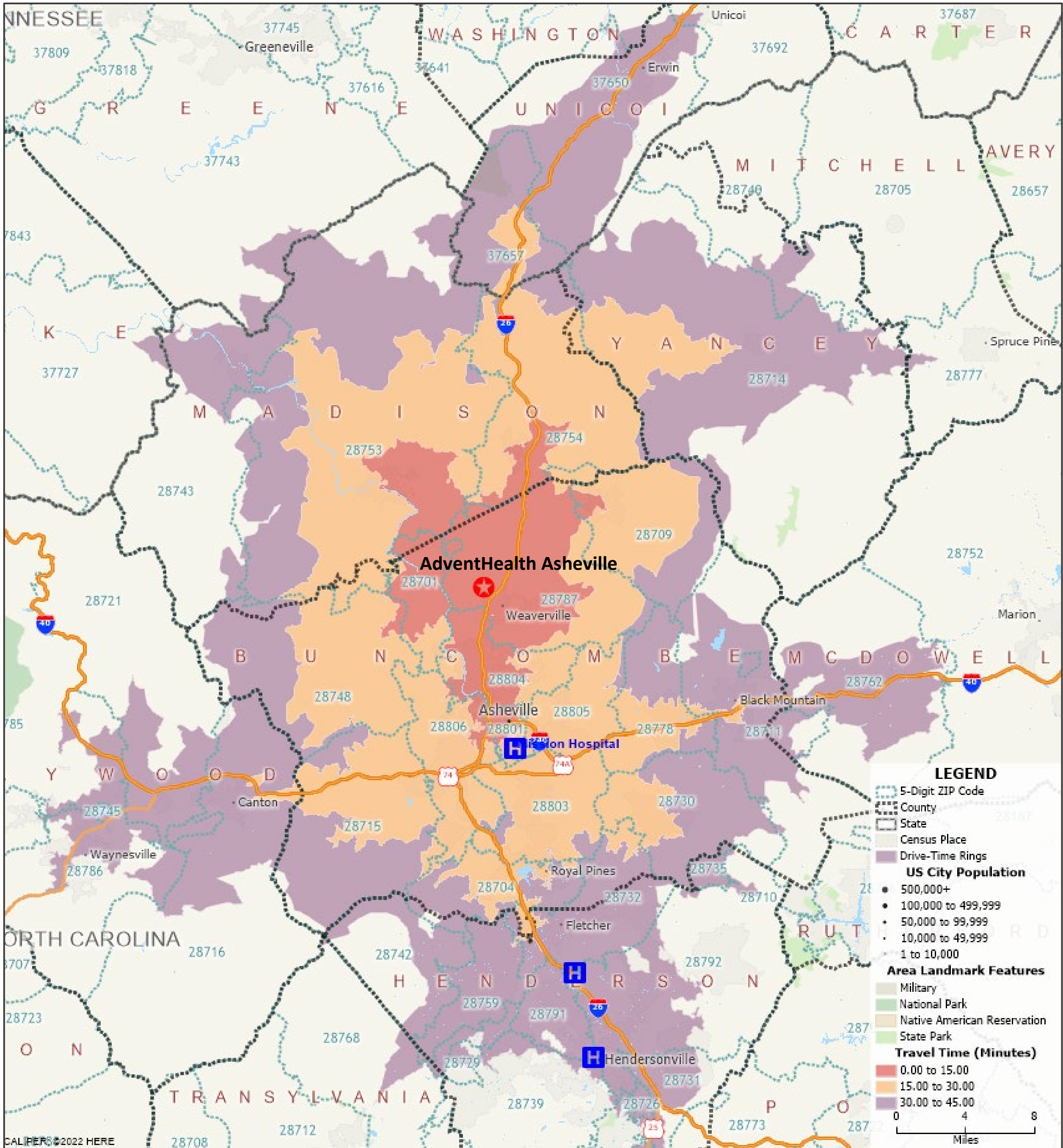
Source: Google Maps

Access for residents of Madison County and Yancey County is crucial in this multicounty acute care bed review because neither county has an acute care hospital. **Every** Madison and Yancey County resident must leave their county to seek acute care services. NHAMC's proposed Arden location is significantly farther for Madison and Yancey County residents compared to AdventHealth Asheville.

AdventHealth Asheville's new hospital will be developed on approximately 30 acres in Weaverville, Buncombe County. The Weaverville site will serve the population identified in the approved 2022 application, as well as further enhance access for specific service area counties, particularly Madison and Yancey. This new location maintains comparable access for Buncombe County residents and significantly improves access for Madison and Yancey Counties. The Weaverville site places most of Madison County within a 15-30 minute drive and parts of Yancey County within 30 minutes, addressing the travel challenges posed by mountainous terrain, especially during adverse weather. The remote nature of rural, mountainous areas can lead to longer response times for emergency medical services, delaying critical care and potentially worsening health outcomes.

[42] Access for Graham County residents is not significantly different between the AdventHealth Asheville and NHAMC sites.

AdventHealth Asheville Weaverville Site and Approximate Drive Times



Source: Maptitude

The site is conveniently located near Interstate 26 and Highway 70, enhancing accessibility from the broader service area. The hospital will include 26 additional acute care beds, expanding services for Buncombe County and offering closer healthcare options for residents of Madison and Yancey Counties.

Community and provider support for the Weaverville site is strong, emphasizing the benefits of improved access and timely care.

For these reasons, AdventHealth Asheville is the **most effective alternative** regarding geographic access.

Access By Service Area Residents

The 2024 SMFP contains two types of acute care bed service areas: single county and multicounty. Counties with at least one licensed acute care hospital that are not grouped with another county are single county service areas. A multicounty service area is created under two conditions: 1) counties without a licensed acute care hospital are grouped with the single county where the largest proportion of its patients received inpatient acute care services; 2) if two counties with at least one licensed acute care hospital each provided inpatient acute care services to at least 35% of the residents of a county without a licensed acute care hospital, then the county without a licensed acute care hospital is grouped with both of the counties with a licensed acute care hospital.

The 2024 SMFP defines the multicounty acute care service area to include Buncombe, Graham, Madison, and Yancey counties. Facilities may also serve residents of counties not included in their service area.

Generally, regarding this comparative factor, the Agency has previously determined the application projecting to serve the largest number or percentage of service area residents is the more effective alternative based on the assumption that residents of a service area should be able to derive a benefit from a need determination for additional acute care beds in the service area where they live. However, in the 2022 Buncombe/Graham/Madison/Yancey Acute Care Bed Review the Agency determined that this comparative factor was inconclusive due to Mission Hospital's status as a Level II trauma center and tertiary care center. As Mission's 2024 application is not approvable because it does not conform to multiple statutory review criteria, the Agency can and should assess access by service area residents between AdventHealth Asheville and NHAMC.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Projected Service to Service Area Residents – Project Year 3

Applicant	# of Service Area Residents	% Service Area Residents
Mission	25,112	54.8%
Novant Health	568	86.1%
AdventHealth	5,507	90.0%

Source: Section C.3 of competing applications

As shown in the table above, AdventHealth projects to serve the highest number and percentage of service area residents (90%). Novant Health projects that 86.1 percent of patients will originate from the four-county service area. Therefore, AdventHealth is a **more effective** alternative regarding access by service area residents than NHAMC.

Historical Utilization

In previous acute care bed reviews, the Agency has attempted to assess historical utilization among the competing applicants. However, AdventHealth Asheville and NHAMC are not existing facilities and, thus, have no historical utilization. Therefore, this comparative is inconclusive.

Access By Underserved Groups

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

"Medically underserved groups, such as medically indigent or low-income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority."

For access by underserved groups, applications are compared concerning two underserved groups: Medicare patients and Medicaid patients. Access by each group is treated as a separate factor.

Projected Medicare

The following table compares projected access by Medicare patients (for inpatient services) in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicare Revenue: Inpatient Services – 3rd Full FY

	Form F.2b	Form F.2b	
Applicant	**Total Medicare Revenue**	**Gross Revenue**	**% of Gross Revenue**
Mission	$3,045,062,572	$5,266,557,560	57.8%
Novant Health	$55,762,271	$98,749,037	56.5%
AdventHealth	$174,322,090	$243,325,264	71.6%

Source: CON applications

AdventHealth Asheville proposed to provide the highest Medicare percentage of gross revenue during the third project year. However, due to differences in the acuity level of patients and the level of care (Level II Trauma center and tertiary care hospital vs. community hospitals) at each facility, a comparison of

average Medicare revenue per patient is likely to be inconclusive in this review, as it was in the 2022 review.

Projected Medicaid

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicaid Revenue: Inpatient Services – 3rd Full FY

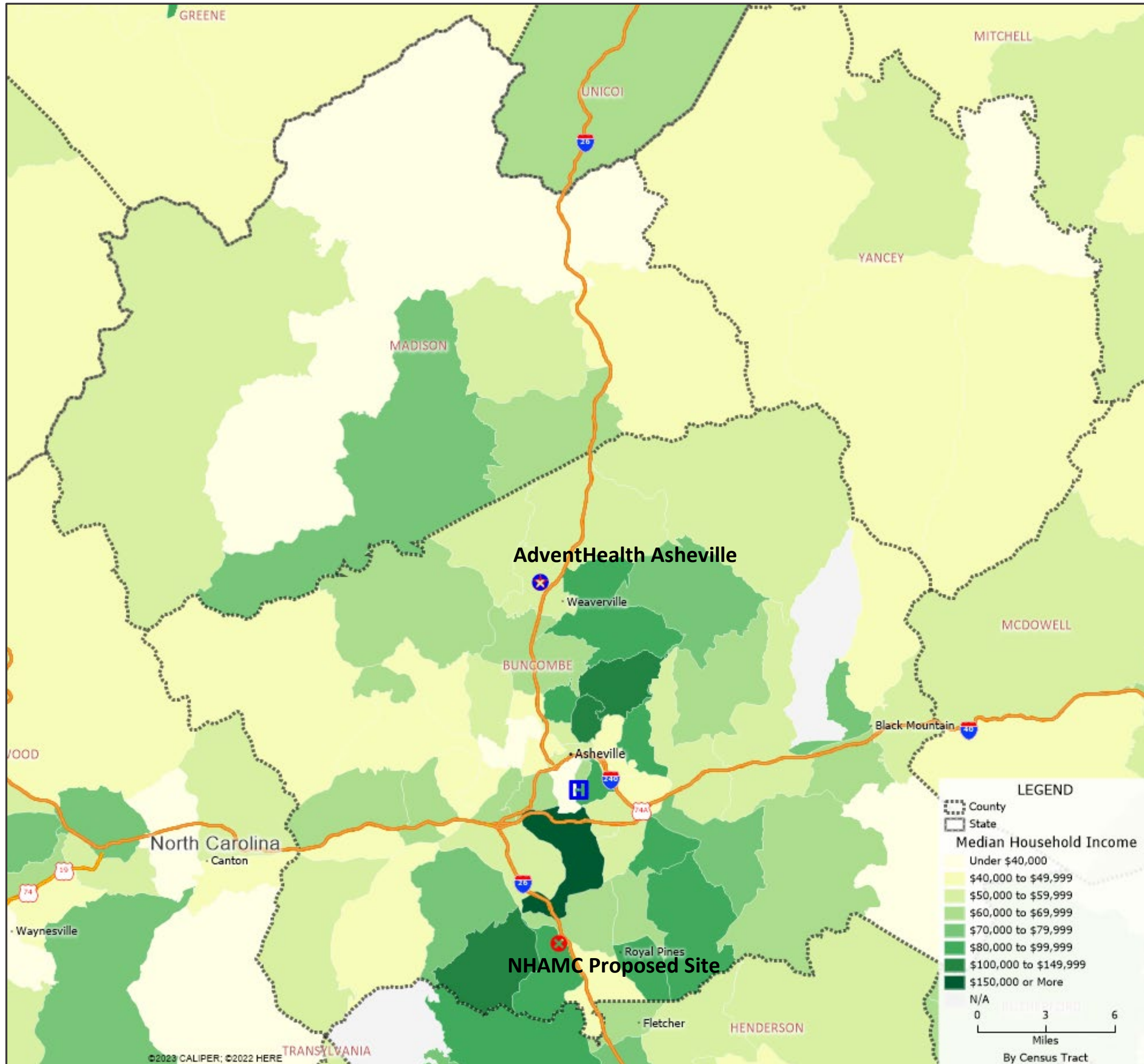
Applicant	Form F.2b Total Medicaid Revenue	Form F.2b Gross Revenue	% of Gross Revenue
Mission	$605,161,553	$5,266,557,560	11.5%
Novant Health	$9,641,891	$98,749,037	9.8%
AdventHealth	$11,654,263	$243,325,264	4.8%

Source: CON applications

Due to differences in the acuity level of patients and the level of care (Level II Trauma center and tertiary care hospital vs. community hospitals) at each facility, a comparison of average Medicaid revenue per patient is likely to be inconclusive in this review as it was in the 2022 review.

For information purposes, Novant Health's proposed hospital will be located proximate to the most affluent census tract in Buncombe County (see map on the following page) and will be less geographically accessible to underserved patients in Madison and Yancey counties. Therefore, it cannot be an effective alternative regarding Medicaid access.

Median Household Income by Census Tract, 2023



Source: Maptitude

AdventHealth's identified Weaverville site will serve the population identified in the approved 2022 application, as well as further enhance access for specific service area counties, particularly Madison and Yancey. Residents of Madison and Yancey County have higher poverty rates and persons without insurance compared to the state as a whole.

	Buncombe County	Madison County	Yancey County	Graham County	North Carolina
Persons in Poverty, Percent	12.3%	15.0%	14.8%	14.8%	12.8%
Persons Without Health Insurance, under 65, Percent	12.6%	11.8%	14.3%	19.8%	11.1%

Source: US Census Bureau Quick Facts

Projected Average Net Revenue per Patient

The following table shows each applicant's projected average net revenue per patient in the third year of operation, based on the information provided in the applicants' pro forma financial statements (Section Q). Generally, the application proposing the lowest average net revenue is the more effective alternative regarding this comparative factor since a lower average may indicate a lower cost to the patient or third-party payor.

Projected Average Net Revenue per Patient: Inpatient Services – 3rd Full FY

Applicant	Form C.1b Total Discharges	Form F.2b Net Revenue	Average Net Revenue per Discharge
Mission	45,279	$977,289,755	$21,584
Novant Health	1,036	$27,686,876	$26,725
AdventHealth	6,120	$74,049,634	$12,100

Source: CON applications

In the 2022 Buncombe/Graham/Madison/Yancey Acute Care Bed Review the Agency determined that this comparative factor was inconclusive due to Mission Hospital's status as a Level II trauma center and tertiary care center. As Mission's 2024 application is not approvable because it does not conform to multiple statutory review criteria, the Agency can and should assess average net revenue per patient between AdventHealth Asheville and NHAMC.

AdventHealth Asheville projects an average net revenue per discharge that is less than half of what NHAMC projects during the third project year. This comparison of projected average net revenue per discharge is a stark contrast to Novant's allegations that it offers lower rates compared to AdventHealth and HCA.[43] Clearly, Novant's proposed project will not offer a lower cost to the patient or third-party payors.

Projected Average Operating Expense per Patient

The following table shows the projected average operating expense per patient in the third full fiscal year following project completion for each facility. Generally, the application projecting the lowest average operating expense per patient is the more effective alternative concerning this comparative factor to the extent it reflects a more cost-effective service which could also result in lower costs to the patient or third-party payor.

[43] NHAMC application pages 82-83

Projected Average Operating Expense per Patient – 3rd Full FY

Applicant	Form C.1b Patients	Form F.2b Operating Expense	Average Operating Expense per Patient
Mission	45,279	$640,289,776	$14,141
Novant Health	1,036	$34,882,999	$33,671
AdventHealth	6,120	$80,029,172	$13,077

Source: CON applications

In the 2022 Buncombe/Graham/Madison/Yancey Acute Care Bed Review the Agency determined that this comparative factor was inconclusive due to Mission Hospital's status as a Level II trauma center and tertiary care center. As Mission's 2024 application is not approvable because it does not conform to multiple statutory review criteria, the Agency can and should assess average operating expense per patient between AdventHealth Asheville and NHAMC.

NHAMC projects, by far, the highest average operating expense per patient. As explained in AdventHealth's application, development of a specialty hospital with 26 acute care beds is not the most effective alternative for the need determination in the 2024 SMFP. Small-scale inpatient facilities like NHAMC offer a limited range of medical services and do not benefit from economies of scale, leading to higher per-patient costs. Thus, AdventHealth Asheville is comparatively superior to NHAMC regarding average operating expense per patient.

Quality of Care

Given the existing concerns about the quality of care within the service area, it is imperative for the Agency to prioritize this factor in its review process.

For the reasons described in AdventHealth's written comments regarding the Mission application and Criterion (20), Mission is not an effective alternative regarding quality of care.

Novant Health operates and manages 13 hospital licenses (17 facilities) in the state of North Carolina. Novant Health also has 2 CON-approved but not yet operational hospitals: Novant Health Steele Creek Medical Center and Novant Health Scotts Hill Medical Center (NH Scotts Hill).[44] According to Form O (application page 218), Novant Health New Hanover Regional Medical Center (NHNHRMC) is owned by Novant Health. NHNHRMC has maintained a "B" Safety Grade from the Leap Frog Group since Spring 2021.[45] Leapfrog Patient Safety Ratings are publicly available on the Leap Frog Group's website:

[44] NHAMC application page 22

[45] The Leapfrog Group is a national nonprofit organization that collects and transparently reports hospital performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions. The Leapfrog Hospital Safety Grade, Leapfrog's other main initiative, assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections. https://www.leapfroggroup.org/about

https://www.hospitalsafetygrade.org/ Mission Hospital also has "B" Safety Grafe for Spring 2024. AdventHealth Hendersonville has maintained an "A" Safety Grade for several years.

For the third consecutive year, NHNHRMC has received just two out of five stars on the federal government's rating for hospital quality of care. Overall, 22% of rated hospitals received two stars. This means NHRMC scored in the bottom 30% of the nation's rated hospitals, or behind 2,153 hospitals. The data for this survey is through July 2022. Hospital star ratings are publicly available on CMS's website: https://www.medicare.gov/care-compare/ AdventHealth Hendersonville maintains a 5-star overall rating.

NHNHRMC had a finding of immediate jeopardy identified in June 2022, citing "[t]he facility failed to provide a safe environment for patients presenting to the emergency department [in many sampled cases]. ED nursing staff failed to assess, monitor and evaluate patients to identify and respond to changes in patient conditions. The facility staff failed to ensure qualified staff were available to provide care and treatment for patients who arrived in the ED. The cumulative effects of these practices resulted in an unsafe environment for ED patients."[46] See AdventHealth's written comments regarding the Mission application and Criterion (20), for information related to Mission's recent immediate jeopardy. AdventHealth has not received any notices of Immediate Jeopardy at AdventHealth Hendersonville in recent years.

As shown in the following summary table which compares quality scores and recent licensure deficiencies for hospitals in each of the applicant health systems, AdventHealth is the most effective alternative regarding quality of care in this review.

	AdventHealth Hendersonville	Novant Health NHRMC	Mission Hospital
Leap Frog Patient Safety Grade Spring 2024	**A**	B	B
CMS Hospital Compare: Overall Star Rating	**5 out of 5**	2 out of 5	4 out of 5
CMS Hospital Compare: Patient Survey Rating	**4 out of 5**	3 out of 5	2 out of 5
Recent Immediate Jeopardy Notice (IJ)	**None**	Yes	Yes
Conclusion	**Most Effective**	Less Effective	Less Effective

Source: CMS & The Leap Frog Group

[46] McAdams, A. (24 Aug 2022) Report from feds details many problems at NHRMC Emergency Room that put patients in 'Immediate Jeopardy' https://www.wect.com/2022/08/24/report-feds-details-many-problems-nhrmc-emergency-room-that-put-patients-immediate-jeopardy/

Summary

For each of the comparative factors previously discussed, AdventHealth Asheville's application is determined to be the most or more effective alternative for the following factors:

- Conformity with Review Criteria
- Scope of Services
- Geographic Accessibility
- Enhance Competition
- Access by Service Area Residents
- Quality of Care

Mission's application fails to conform with all applicable statutory and regulatory review criteria; thus, it cannot be approved. In addition, Mission's application fails to measure more favorably for the aforementioned comparative factors.

Novant Health's application fails to conform with all applicable statutory and regulatory review criteria; thus, it cannot be approved. In addition, Novant Health's application fails to measure more favorably for the aforementioned comparative factors.

Based on the previous analysis and discussion, the application submitted by AdventHealth Asheville is comparatively superior and should be approved for this competitive review.

Conclusion

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of acute care beds that can be approved by the Healthcare Planning and Certificate of Need Section. The applicants collectively propose to develop 78 acute care beds in Buncombe County. Based on the 2024 SMFP's need determination, only 26 acute care beds can be approved.

AdventHealth Asheville is the only application fully conforming to all statutory and regulatory review criteria. Furthermore, AdventHealth Asheville is comparatively superior to the Mission and Novant Health proposals. AdventHealth Asheville will:

- Enhance scale and scope at the approved acute care hospital to help meet the growing demand for acute care services in the service area,
- increase patient access to acute care services in the service area,
- enhance geographic access to acute care services in the service area;
- provide more opportunities for dedicated medical professionals to build their careers in the local community; and
- enhance patients' and families' choice for acute care services in Buncombe County.

Thus, the application submitted by AdventHealth Asheville is the most effective alternative and should be approved as submitted.

Attachments:

Attachment 1: Mission Plan of Care Submission to CMS

Attachment 2: CMS Revisit Survey Findings

Attachment 3: Blue Ridge Regional Hospital Survey Documentation

Attachment 4: Excerpts from Agency Findings from 2011 Wake County Nursing Home Review

Attachment 5: Copies of Articles Referenced in Written Comments

Attachment 6: Comparative Analysis Factors (Suggested)

Attachment 1:

Mission Plan of Care Submission to CMS

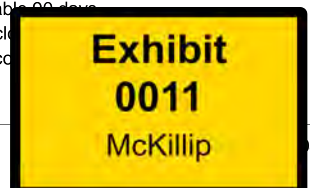
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______________________ B. WING __________________________	C **12/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 000	INITIAL COMMENTS A complaint investigation was conducted November 13, 2023, through November 17, 2023; November 27, 2023 through December 1, 2023; and December 4, 2023 through December 9, 2023 to evaluate the hospital's compliance with the Medicare Conditions of Participation. The investigation resulted in the identification of Immediate Jeopardy (IJ) to patients' health and safety on December 1, 2023, at 1200 as a result of incidents that occurred on 08/14/2023; 07/05/2022; 07/04/2022; 04/05/2022; 10/03/2023; 10/31/2023; and 10/17/2023. Specifically, pursuant to §482.13 Patients' Rights, §482.23 Nursing Services and §482.55 Emergency Services, the hospital nursing staff failed to ensure a safe environment for the delivery of care to emergency department patients by failing to accept patients on arrival to the emergency department resulting in delays or failure to triage, assess, and implement orders. A provider in the Emergency Department failed to provide safe care and did not evaluate a patient's critical condition and sounding alarms upon a family's request. 1. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (Clinical Institute Withdrawal Assessment - assessment tool used for alcohol withdrawal) at 1841, and Ativan	A 000	Mission Hospital holds the safety of all patients, staff, and visitors as its highest priority. Immediately on receipt of survey findings, the senior leadership team met and initiated intensive review and root cause analysis (RCA) of each of the findings, formulating a plan of correction to fully address all tags identified as out of compliance, resulting in system changes as identified within this report. Based on this intensive analysis including RCAs, review of medical records cited, policies, procedures, and practices currently in place, along with staff interviews, a comprehensive plan of correction was formulated and reviewed by the Quality Committee (QC), Medical Executive Committee (MEC), and Board of Trustees (BOT). A multidisciplinary leadership team formulated this Plan of Correction (POC) to fully address all CMS tags identified as out of compliance which resulted in the system changes documented in this report. Based on this intensive analysis including RCAs, review of medical records, policies, procedures, and practices currently in place, along with staff interviews, a comprehensive plan of correction was formulated and reviewed by the Quality Council, Patient Safety Committee, Medical Executive Committee (MEC), and Board of Trustees (BOT). This plan of correction is intended to demonstrate the facility's commitment to compliance with applicable state and federal requirements. The following team members contributed to the review and implementation of this corrective action plan: Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Associate Chief Medical Officer (ACMO), Associate Chief Nursing Officers (ACNOs), Vice President Emergency Department, Emergency Department Medical Director, Laboratory Medical Director, Laboratory Director, and Vice President of Quality.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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 disclo[illegible] days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to co[illegible] program participation.



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Continued From page 1

(medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury.

2. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest.

3. Patient #27 arrived in the ED on 07/04/2022 at 0025 with abdominal pain reported as a pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0028 that resulted at 0755 (7 hours and 27 minutes after ordered) as positive for a small bowel obstruction. Orders for STAT lab work were placed at 0028. Lab

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Upon notification of Immediate Jeopardy (IJ) from the NCDHHS, on Friday December 1, 2023 the Mission Hospital team promptly began implementing mitigation and process changes to ensure alignment with the Conditions of Participation (CoPs) identified under Nursing Services, Emergency Services, and Patient Rights. An IJ abatement plan was submitted and presented to the state surveying agency (NCDHHS) on December 4, 2023 with actions believed to be sufficient to address and abate the IJ situation identified; this plan of abatement was further enhanced through the comprehensive plan of correction submitted (and subsequently detailed below) February 6, 2024 and will continue to be enhanced through clarification and ongoing dialogue and feedback from NCDHHS and CMS Office, Region 4. Immediate actions (began December 1, 2023 and continue through current day) included:

- Memo to all Medical Staff setting expectations around responsiveness to emergent patients, as noted in the comprehensive plan of correction associated with A-tags A068, A092
- Review of Arrival to Triage performance, audit, and process changes for EMS and Walk in patients, as further defined in the comprehensive plan of correction associated with A-tags A068, A092, A385, A392, A398, A1100, and A1101
- Review of Arrival to EKG audit process, as further defined in the comprehensive plan of correction associated with A-tags A068, A092, A385, A392, A398, A1100, and A1101
- Review of Medication Assessment/Reassessment audit process, as further defined in the comprehensive plan of correction associated with A-tags A068, A092, A385, A392, A398, A405, A1100, and A1101

- Review of Lab order to collect audit process, as further defined in the comprehensive plan of correction associated with A-tags A576 and A583
- Review of Education provided to Emergency Department (ED) staff and providers as appropriate and individually defined in each section of the comprehensive plan of correction
- Review of EMS Offload Focused Initiatives, as further defined in the comprehensive plan of correction associated with A-tags A068, A092, A392, A398, A1100, and A1101

Plans and actions to ensure sustained processes to ensure safe care of patients in the Emergency Department have been instituted by Mission Hospital. This detail, outlined in the following plan of correction, was further enhanced December 9, 2023 at the end of the onsite survey, December 19, 2023 during the exit conference with the NCDHHS team, and following transmittal of the 2567 document from CMS on February 1, 2024. These actions, **outlined in the comprehensive plan of correction include:**

- Development and implementation of an ED Front End Redesign to maximize efficiencies and throughput
- Addition of ED, inpatient, and support staff to provide additional inpatient capacity and support ED throughput
- Reviewed and updated ED ligature risk assessment and supporting education provided
- Additional education to ED staff and providers
- Additional education to inpatient staff and patient safety attendants
- Additional audit and supporting education around inpatient hygiene
- Additional audit and supporting education around patient safety attendant rounding
- Additional audit and supporting education around CIWA assessments
- Additional audit and supporting education around initial treatment for wound care orders
- Performance improvement project and supporting education around CT order to start delays
- Additional audit and supporting education around implementation of continuous telemetry monitoring in the ED

Summary of policies/guidelines and any other documents reviewed or revised during POC development:

- Assessment/Reassessment, 1PC.ADM.0013
- Pain Assessment and Management, 1PC.ADM.0002
- Physiologic Monitoring – Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring, Non-Invasive Blood Pressure Monitoring (NIBP), 1PC.NRS.0001
- Triage – Emergency Department, 1PC.ED.0401
- Triage Treatment Guidelines – TTGs, 1PC.ED.0402
- Turn Around Time, 2LAB.AD.0502.00
- Rounding Tasks and Collection Expectations, 2LAB.PHB.5050.00
- COA Form
- Patients at Risk for Suicide in Non-Behavioral Health Settings: Identification and Monitoring, 1PC.PSY.0102
- Emergency Department Ligature Risk Assessment
- CIWA Withdrawal Plan 2/22

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Continued From page 2

results were completed at 0734 (7 hours and 6 minutes after ordered). The patient had pain reported as 10 of 10, with nausea and vomiting on arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). Orders were written at 0028 for IV (intravenous) fluids and Ondansetron (medication for nausea). The IV fluids were started and medication for nausea was administered at 0739 (7 hours and 11 minutes after originally ordered). Findings revealed no lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 6 min). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

4. Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% on oxygen prior to arrival. At 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid (narcotic pain medication) 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital signs or oxygen assessment on an elderly patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently found unresponsive in a hallway bed, in asystole at 1909 and expired. Patient #29 had one set of vital signs completed from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to monitor and evaluate the patient for

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A 000	Continued From page 3 a change in condition (not breathing). 5. Patient #6 arrived to the ED as a transfer on 10/03/2023 at 1942 by EMS. The patient was 10 days postpartum in a hypertensive crisis with stroke-like symptoms, including left facial droop, left arm and left leg weakness. Magnesium Sulfate IV was started en route. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment, and monitoring by nursing staff. 6. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS with a hemorrhagic stroke. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neuroscience's Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 7. Patient #2 was brought into the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a Syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after the lab were ordered), after the patient was triaged at 1900 (1 hour and 7 minutes	A 000		

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A 000	Continued From page 4 after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was obtained until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care, and treatment. Facility leadership staff was notified on the Immediate Jeopardy (IJ) identification on December 1, 2023, at 1200. The IJ was determined to be ongoing. Specifically, pursuant to §482.13 Patients' Rights, §482.23 Nursing Services and §482.55 Emergency Services, the hospital nursing staff failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) by failing to limit environmental risks in the Emergency Room Pods (cluster of rooms in a designated area) used to house Behavioral Health patients awaiting placement (Green Pod and Purple Pod) and failed to ensure ongoing evaluation, monitoring, and implementation of orders, including lab, telemetry, and medication orders without delays. 1. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The	A 000		

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A 000	Continued From page 5 patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate (heart arrhythmias). Findings of an EKG at 2110 showed ST elevation, **ACUTE MI/STEMI (heart attack)**. A STEMI Code Activation was initiated for an evolving lateral STEMI. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. 2. Patient #83 presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours ordered at 1739 were never initiated. At 2329 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was canceled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at	A 000		

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A 000	Continued From page 6 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hour and 36 minutes after ordered) with result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Observations on 11/13/2023 during the tour of the ED revealed the Green Pod had twelve patient rooms, eight of which housed adolescent behavioral health patients. Only three of the eight patients had a sitter at the door. All of the patients had a corded call bell in the room. Tour of the Purple Pod, on the same day, revealed twelve patient care rooms. Eleven of the rooms housed patients. Each patient had corded call bells. There were two sitters available for the eleven patients. Facility leadership staff was notified on the IJ identification on December 9, 2023, at 1700. The IJ was determined to be ongoing.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on policy review, Quality Performance Improvement Plan review, medical record review,	A 043	**Subject of Deficiency – A 043** The hospital's governing body failed to provide oversight and have systems in place to ensure the protection and promotion of patient's rights to ensure a safe environment for emergency department patients; failed to maintain an organized and effective quality assessment and improvement program; failed to have an organized nursing service to meet patient care and safety needs and failed to meet the emergency needs of patients.	

Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below.

Plan of Correction:
The governing body of Mission Hospital is dedicated to the oversight of this plan of correction and the continued improvement required to facilitate the needs of our patients and the community.

As such, the governing body is fully informed of the conditions of participation deficiencies cited herein and will continue with the oversight necessary to fully address these deficiencies. The governing body believes that the multidisciplinary leadership team used to formulate this plan of correction fully addressed all CMS tags identified as out of compliance and that there are system changes in place necessary to achieve continued compliance.

The plan of correction demonstrates the facilities commitment to compliance with all applicable conditions of participation requirements.

Action:
The Chair of the Medical Executive Committee (MEC) and the MEC were informed of the survey deficiencies during the regularly scheduled committee meeting. The Mission Hospital Board of Trustee's (BOT) were notified of survey deficiencies and findings via e-mail on 2/2/24.

2/2/24

Monitor for Compliance:
The governing body will provide oversight of the plan of correction implementation and sustained improvements.

All ongoing actions, monitoring activities and results will be reported monthly to the Quality Council and all other appropriate committees and the MEC/BOT (per individual schedules) beginning in February of 2024. If the team identifies significant variations in the POC the MEC/BOT will be informed as soon as possible and will review the appropriate course of action. This reporting structure will be maintained for at least 4 months and continue as indicated to maintain compliance.

Owner: Chief Executive Officer/COO

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A 043	Continued From page 7	A 043		

Emergency Medical Services (EMS) trip report review, incident report review, observations, environmental risk assessment review, pharmacy unit inspection review, personnel file review, hospital document review and staff and provider interviews, the hospital's governing body failed to provide oversight and have systems in place to ensure the protection and promotion of patient's rights to ensure a safe environment for emergency department patients; failed to maintain an organized and effective quality assessment and improvement program; failed to have an organized nursing service to meet patient care and safety needs and failed to meet the emergency needs of patients.

The findings included:

1. The hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26).

Cross refer to §482.12 Governing Body Standard: Tag A 0068.

2. The hospital's leadership failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the emergency department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing

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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) COMPLETION DATE
A 043	Continued From page 8 assessment, and implementation of orders, including lab, telemetry and medication orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.12 Governing Body Standard: Tag A 0092. 3. The hospital staff failed to ensure a safe environment for behavioral health patients subject to self-harm in the ED by failing to limit environmental risks in the Emergency Room pods (cluster of rooms in a designated area) used to house Behavioral Health patients awaiting placement (Green Pod and Purple Pod). Cross refer to §482.13 Patient Rights' Standard: Tag A 0144. 4. The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for 7 of 94 sampled patients reviewed (#58, #27, #59, #50, #13, #50, #2). Cross refer to §482.21 Standard: QAPI Quality Improvement Activities, Tag A 0286. 5. The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action for 7 of 94 sampled patients reviewed. (#58, #27, #59, #50, #15, #13 and #2). Cross refer to §482.21 Standard: QAPI Standard:	A 043		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 043	Continued From page 9 Tag A 0309. 6. The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatment in the emergency department for 4 of 35 sampled ED records reviewed (Patients #28, #43, #27, and #2). Cross refer to 482.23 Nursing Standard: Tag A 0392. 7. The hospital's nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.23 Nursing Standard: Tag A 0398. 8. The hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered and evaluate and monitor the effects of the medication for 6 of 35 patients presenting to the emergency department (#92, #83, #43, #28, #27, and #26). Cross refer to §482.23 Nursing Standard: Tag A 0405. 9. The hospital staff failed to have available laboratory services to meet the identified turn	A 043		

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A 043	Continued From page 10 around times for STAT results for 3 of 35 patients presenting to the hospital's emergency department (#83, #27, #2), and failed to ensure timely laboratory results for 3 of 3 patients that had lab specimens sent to Hospital A's lab from Hospital B (#11, #93 and #94). Cross refer to §482.27 Laboratory Services Standard: Tag A 0583. 10. Emergency department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.55: Emergency Services Standard Tag A 1101.	A 043		
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor;	A 068	**Subject of Deficiency A 068:** The hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered. Each individual Condition of Participation's cross- referenced tag in this section will be outlined in the appropriate tags section below.	

Plan of Correction:

Immediate Actions Taken

Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process
  - 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. — 12/1/23
  - 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage — 12/1/23
  - 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool.
- Arrival to EKG-10 min
  - 12/1/2023 Staff education with attestation — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders involving ED CNC/ED leadership oversight.
- Post Medication Administration Assessment Completed as indicated
  - 12/2/2023 Staff education with attestation — 12/2/23

- 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.
- Order to lab draw-30 minutes
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight.
- Provider response to emergent needs when escalated
  - 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED — 12/2/23
- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
  - 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations — 12/2/23
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
  - 12/2/2023 EKG icon education boost — 12/2/23
  - 12/21/2023 Stethoscope icon — 12/21/23
  - 12/26/2023 Telemetry — 12/26/23
- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS — 12/6/23
- 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).
- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS — 12/6/23
- 12/14/2023 Instituted rapid triage — 12/14/23

process

- 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput.
- 12/9/2024 Trial EMS off-load location set-up
- 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses — 12/12/23
- 12/13/2023 Trial EMS off-load process
- 12/14/2023 Tracking and trending of implementation of EKG orders — 12/14/23
- 12/20/2023 ED CMU escalation pathway education and implementation — 12/20/23
- 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. — 12/29/23

Ongoing Actions:

Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
    - 1/5/2024 direction was given for closed loop communication within 60 minutes of escalated — 1/5/24

Plan of Correction	Completion Date
barriers via internal communication tool	
• ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons	
o 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments	2/1/24
• 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include:	1/20/24
o 1/25/2024 Modification of HCG order process to streamline results	1/25/24
o 1/30/2024 Structured communication to close loop on identified opportunities for improvement	1/30/24
o 1/30/2024 Standardized process to facilitate patient readiness for CT	1/30/24
• 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS	1/22/24
• 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours	1/26/24
• 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.	1/30/24
• 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design	1/30/24
o 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours	1/5/24
o 1/5/2024 Developed triggers for triage escalation and posted at triage desk	1/5/24
o 1/5/2024 Assessment/Re-assessment policy review	1/5/24
o 1/11/2024 Due diligence walk through with ER Operations and IT	1/11/24
o 1/11/2024 Front-end multidisciplinary team design session	1/11/24
o 1/12/2024 Assessment/Re-assessment policy approved by CNO and Nursing	1/12/24

Plan of correction	Completion date
Operations Council	
o 1/12/2024 Staff participated in organization and set-up of Critical Supply Room	1/12/24
o 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors	1/12/24
o 1/13/2024 Mock set-up of room 32	1/13/24
o 1/15/2024 Addition of script printer in room 115	1/15/24
o 1/15/2024 IT refresh complete	1/15/24
o 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG	1/16/24
o 1/16/2024 Capital PO issued for 4 portable cardiac monitors	1/16/24
o 1/16/2024 Added additional monitor to Air Traffic Control (ATC) desk to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals	1/16/24
o 1/17-29/2024 Reconfigured front-end area	1/29/24
o 1/17/2024 Per staff request, 3 additional vital sign machines provided	1/17/24
o 1/17/2024 Front-end multidisciplinary team education and roles and responsibilities review	1/17/24
o 1/18/2024 Front-end education of ER providers in January provider meeting by ER Medical Director	1/18/24
o 1/23/2024 Standardization of supply carts	1/23/24
o 1/18/2024 Confirmed Team Health Leadership participation during 1/30 go-live	1/18/24
o 1/18/2024 Standardization and escalation of Pharmacy order verification under the MAR education	1/18/24
o 1/18/2024 Worked with pharmacy to standardize medication storage units	1/18/24
o 1/18/2024 Added medication refrigerator to the medication storage unit	1/18/24

- 1/18/2024 Educate staff on defined roles/responsibilities and standard work flow — 1/18/24
- 1/19/2024 Designated location for discharge paperwork and standardized process — 1/19/24
- 1/22/2024 Streamlined laboratory process for COVID, Flu, and RSV to improve timeliness of results — 1/22/24
- 1/23/2024 Confirmed 100% of providers received education on front-end process re-design — 1/23/24
- 1/24/2024 Front-end multidisciplinary team Go/No Go meeting with decision to move forward — 1/24/24
- 1/25/2024 Launch discharge print button to support greater efficiency for the providers to print discharge instructions — 1/25/24
- 1/26/2024 Greet tracker installed in provider area — 1/26/24
- 1/26/2024 Streamlined laboratory process to expedite results for HCG — 1/26/24
- 1/26/2024 6 workstations on wheels (WOW) deployed for provider and CNC documentation efficiency (decreased time from arrival to first clinical order) — 1/26/24
- 1/29/2024 Increased staff efficiency by stocking blood culture bottles in all areas — 1/29/24
- 1/30/2024 Created intake teams to perform MSE, nursing documentation, and implement initial interventions in Internal Processing Area (IPA) — 1/30/24
- 1/30/2024 Deployed 4 portable cardiac monitors — 1/30/24

Education:

Education provided to currently working eligible and targeted staff and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include

(7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals — 12/2/23
- 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight — 12/2/23
- 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals — 12/2/23
- 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol — 12/2/23
- 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment — 12/14/23
- 12/21/2023 ED nursing staff education regarding telemetry order initiation — 12/21/23
- 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process — 12/21/23
- 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff — 12/21/23
- 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway — 12/21/23
- 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversations with nursing staff completed by education team — 1/15/24
- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front-end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24

- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation

2/6/24

Monitoring for Compliance/Audit Details:

Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- o Arrival to Triage Times for walk-in and EMS
- o Arrival to EKG order-to-complete per policy/protocol
- o Pain Medication assessment/ reassessment per policy/protocol
- o CIWA assessments per policy/protocol
- o Realtime escalation of patient safety concerns
- o CT order to exam

Sustained Compliance Audits to Ensure POC is Effective:
Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to-completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.

- Numerator = # of compliant EKG order-to-completion per policy/protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends

- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ Chief Medical Officer/ACNO/VP Emergency Services

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A 068	Continued From page 11 or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on policy review, medical record review, Emergency Medical Services (EMS) trip report review, incident report review, and staff and provider interviews, the hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). The findings included: Review of the Quality Improvement Plan approved by the hospital Chief Executive Officer (CEO), Board of Trustees Chair and Chief Medical Officer (CMO) on 04/24/2023 revealed, " ...The hospital-wide Performance Improvement Plan is designed to improve quality performance and patient safety, ultimately reducing the risk to patients. ... ACCOUNTABILITY ... The following individual and/or committees are accountable for setting expectations, developing plans, and implementing procedures to assess, improve quality, and measure performance improvement within the organization.......Medical Executive Committee ......Medical Staff / Medical Staff Department Chairman. The Medical staff shall be	A 068		

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A 068	Continued From page 12 responsible to participate in the Performance Improvement Plan to the degree necessary and appropriate to achieve the purpose of the plan. Medical Staff members will be appointed to various Medical Staff Committees. These committees shall be responsible for implementing and maintaining an effective system to monitor and evaluate the quality and appropriateness of care ... The medical staff department chairs will participate in the Campus Executive Committee or Medical Executive Committee, as applicable. Participation will include monitoring metrics, developing criteria, evaluating results, ensuring resolution, and reporting findings to the appropriate medical staff department......" Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS:.... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. 2. A comprehensive assessment, performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale,	A 068		

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A 068	Continued From page 13 allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the patient will need to wait in the lobby. While in the lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines....."	A 068		

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A 068	Continued From page 14	A 068		

Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. .... The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated, and immediate life-threatening needs are determined with appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial, physiological, and age-specific needs of the individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 15 indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...." 1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and labs including CBC, chemistry, lipase and troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 16 abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 17 Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization. ..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis of STEMI (ST elevation myocardial infarction), Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR.	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 18 Interview on 12/09/2023 at 1210 with ADON #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to ensure a safe environment for the delivery of care to Patient #92 by failing to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. 2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 19 placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. " Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of dizziness from her doctor's office. Patient #83 was seen by an ED MD #1 on arrival and at 1218 a comprehensive metabolic panel (CMP)	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 20 [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 RN #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an inpatient bed. At 2329 Hospitalist MD #9 ordered an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). On 11/29/2023 at 0127 MD #9 ordered a Lactic	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 21 Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these , later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 cancelled the 0127 NOW Lactic Acid order "nurse collect" from the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes after ordered) with result of 12.3 (normal high range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was in the lab for processing at 0907, and resulted at	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 22 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337. Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 23 Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work. Request to interview MD #9 revealed she was unavailable for interview. Request to interview MD #16 revealed he was unavailable for interview. Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed. Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble getting in contact with the phlebotomist. That morning they were not logged into to their imobile device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 24	A 068		

telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I strongly advocated for her to get moved into a bed with the CNC (clinical nurse coordinator), and it didn't happen. She didn't think it was a big deal. We don't have the capability to link the patient to

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 25 a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83. Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83. Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 26 STAT lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol Withdrawal Plan, effective date 07/20/2022 revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less than) 15..." The CIWA/Alcohol Withdrawal Plan Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 27 each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10.Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..." Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, ekg, and chest Xray were completed, and Patient #43 was assigned to ED Medical Doctor (MD) #23. Review of the ER Physician Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, ekg and chest Xray results from 08/14/2023 did not show any critical results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for	A 068		

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A 068	Continued From page 28 indigestion), Zofran 4mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and a CIWA Scale reassessment was due to be completed per protocol. No nursing reassessments, medication administrations, IV access/fluids, or physician orders were completed after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was	A 068		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 29 moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was documented before the patient had a seizure event with sustained head injury. There was no nursing reassessment, or nursing care after 08/14/2023 at 1851 by RN #22 until 08/15/2023 at 0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at	A 068		

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A 068	Continued From page 30	A 068		

0334 from the ED. Patient #43 was discharged home on 08/17/2023.

Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to sent out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload."

Request to interview MD #23 revealed she declined the interview.

Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be monitored ..." Interview revealed MD #26 had concerns for patient safety in the ED waiting room due to delays in patient monitoring.

Interview on 11/15/2023 at 1615 with NP #36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 31	A 068		

revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 068	Continued From page 32 might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43. Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not been completed. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 33 for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency severity index (ESI) of 1-Resusicitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG, lab work, chest Xray and CT (cat scan) of the head. At 1005 Haldol (given to treat severe behavior) 10 mg Intravenous was ordered by MD #59 and given due to combativeness. Review of	A 068		

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A 068	Continued From page 34 the ER Note by MD #59 dated 07/05/2023 at 1002 revealed "..... history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now, ... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed.. The Head CT was negative. Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes. We have been running norepinephrine (given to sustain blood pressure) through this. ICU (intensive care unit) has been	A 068		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 35 consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the	A 068		

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A 068	Continued From page 36	A 068		

family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040.

Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment

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A 068	Continued From page 37 was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 38 "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 39	A 068		

Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation.

Request to interview ED RN #68 revealed she was not available for interview.

Request to interview ED RPH #78 revealed she was unavailable for interview.

Request to interview ED Manager RN #75 revealed he was unavailable for interview.

Request to interview ED Director, RN #76 revealed she was unavailable for interview.

Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 40 explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available for this surveyor). Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull resources..." Further interview with CNC RN #74 revealed "...she had no concerns with nursing reassessments in the ED... that nursing assignments in the Red Pod (where the most	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 41 acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care. Interview on 11/15/2023 at 1637 with VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed. Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 42	A 068		

#77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him.

Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did.

Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 43 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

A 068 Continued From page 44 A 068

vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136.

Request for a Patient Safety Report (Incident Report) revealed there was not one available.

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any labs or orders completed. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 45	A 068		

Continued From page 45

that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022.

Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.

Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 46	A 068		

pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters. Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain medication, antibiotics, and lab work." PA #45 ordered X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients) Hallway Bed 7. At 1517 Patient #29 was triaged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 47 by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2. 20g Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), RN #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5mg IV for a pain score of 10/10 and Zofran 4mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain reassessment was charted as 9/10 (no evidence of an oxygen reassessment). At 1748 the Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open tibial shaft fracture..." with plan for surgery to	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 48	A 068		

repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (no evidence of this in the record). She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at 1909.

Review of the Patient Event Record dated 04/06/2022 at 0341 by Nursing/Surgical Services #54 revealed the event was "unexpected death" date of event "04/05/2022 at 1903" with narrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 49	A 068		

"...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsivein hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to event per report.

Request to interview Trauma Nurse, RN #56 revealed she was unavailable for interview.

Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital policy for reassessment was not followed for Patient #29.

Telephone interview on 11/16/2023 at 1324 with MD #46 revealed she did not recall Patient #29. Interview revealed "...monitoring of patients in

(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) COMPLETION DATE
A 068	Continued From page 50	A 068		

hallway beds are a concern. Ideally every patient in the Red Pod should be on some sort of a monitor with a pulse oximeter. More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside.

Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29.

Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be placed on a cardiac monitor which showed asystole. At 1909 was the time of death pronounced with her daughter at the bedside. Interview revealed this event was reviewed by the Mortality and Morbidity which was comprised of multiple providers and the MD who had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
A 068	Continued From page 51	A 068		

completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.)

Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing).

7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood thinners and 10 days post partum. What aspect of reason for visit is concerning to patient? : Stroke symptoms....... " Review of a MD "ER Report", service date/time 10/03/2023 at 1714,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 52 revealed " ... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the fact the patient is 10 days postpartum which does place her at an elevated risk for ischemic CVA (stroke). Differential at this point would also include complex migraine,	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 53 preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke...... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most urgent transport)......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no obvious distress....report is as follows: .....Dx (Diagnosis): HTN (hypertension) crisis, Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 54 weakness and tingling onset. ...10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and leg weakness along with a facial droop and neck pain. Vital signs continued approximately every 5 minutes, with the last recorded blood pressure 147/90 at 2215.	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 55 Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H .....ED Full Triage Arrival Mode - ED (Emergent) : EMS .....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital....." Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form. ... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry neurologist decision was made against using tPA (breaks down blood clots). She was transferred here for further stroke eval and MRI (magnetic resonance imaging). She was also notably hypertensive at outside hospital with blood pressure 160s systolic. She has also had some	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 56 headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here. Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop Preeclampsia...... " Record review failed to reveal acceptance and monitoring of Patient #6 by nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 57	A 068		

documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023.

Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring.

Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 58	A 068		

assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia.

Telephone interview with Patient #6's Triage Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation. Interview revealed the EMS team was responsible for any patient they brought in until the patient got a room assignment and was moved to a room in the ED. Once the patient was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 068	Continued From page 59	A 068		

in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN.

Telephone interview on 11/17/2023 at 1205 with MD #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics.

Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 60 assessment and monitoring. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed "...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed "....History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)......Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with neurologic symptoms concerning for acute ischemic stroke I think she will likely be a candidate for thrombolytics assuming that we can get her blood pressure down. She is going to CAT (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 61 labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. ...." Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority. Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). .....THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED ....THE PHYSICIAN ADVISED TARGET BLOOD PRESSURE IS 140/90 AND ADVISED TO MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 62 ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE...... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT .... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED ......" Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and hand-off to the hospital. Review of the Hospital A medical record for Patient #1, on 11/14/2023, revealed the patient arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351,	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 63 revealed "... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management....Physical Exam......Initial Vitals No Data Available ....Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making .... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ..." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated "...Impression and Plan:.....#ICH (Intracranial Hemorrhage): hypertensive etiology suspected .... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on one side of the body). Plan: admit to ICU for close neurologic monitoring. ..." Review of the ED record failed to reveal any vital signs or assessments by nursing. Review revealed "Nurse Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 64 (Name), RN. ED CNC (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85. Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED. Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients in the ED as soon as they were notified of the patient's arrival. Interview revealed it was "surprising" not to have vital signs completed in the ED and stated it did not meet expectations for	A 068		

A 068

Continued From page 65

care - patients needed hourly neuro checks and vital signs with provider updates on changes.

Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN.

Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done

A 068

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 068	Continued From page 66 at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE BIG TOE OF HIS LEFT FOOT. IT WAS NOW NOTED THAT PT'S EKG WAS SHOWING ... ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 67 A&Ox4..... PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN. ....." EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care ......" Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 68 Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7. Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed "... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks. .. He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic, Diflucan (antifungal), and Duricef (antibiotic)....Medical Decision Making.... EMS reports that they gave patient 324 mg aspirin....blood pressure was approximately 96 mmHg. They gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that patient had 7 beat run of V tach on their EKG tracing in route with patient now in sinus rhythm and occasional bigeminy. Ordered EKG and for patient to be on telemetry....Point-of-care CBG	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 068	Continued From page 69 (blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach....1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017.....Called lab to request results of chemistries be available as soon as possible. Labs resulted after arrest ... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack). Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING _______ B. WING _______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 068	Continued From page 70 and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm.....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For this patient who presented with chest pain, syncope, and suffered cardiac arrest has either suffered an MI or rhythm disturbance.....I reviewed his medications..... I made attempts to	A 068		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 068	Continued From page 71	A 068		

address .....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole .....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46 ... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest. ..."

Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17 minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently and it seemed like a staffing issue.

Telephone interview with PA #71, on 11/15/2023

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 72 at 1600, revealed the patient came into the ED with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival. Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient #2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in a room and care handed-off from EMS, interview revealed, they were "counting on EMS to care for (the patients)......"	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 068	Continued From page 73	A 068		

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol, but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started.

Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. The hospital staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment.

10. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 068	Continued From page 74 abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival). Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be seen by providers and prescribed medications while "on the wall" but can not get them because no RN has been assigned.	A 068		

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A 068	Continued From page 75 11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention". Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...". Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the	A 068		

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A 068	Continued From page 76 patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	A 068		
A 092	EMERGENCY SERVICES CFR(s): 482.12(f)(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on policy review, medical record review, incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, hospital leadership failed to	A 092	**Subject of Deficiency:** The hospital's leadership failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the emergency department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders. Each individual Condition of Participation’s cross-referenced tag in this section will be outlined in the appropriate tags section below. Each individual Condition of Participation’s cross-referenced tag in this section will be outlined in the appropriate tags section below.	

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A 092

Continued From page 77

ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the emergency department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26).

The findings included:

Cross refer to all findings at §482.55: Emergency Services A 1100.

Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26).

1. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate,

A 092

Plan of Correction:
Immediate Actions Taken
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process
  - 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. — 12/1/23
  - 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage — 12/1/23
  - 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool.
- Arrival to EKG-10 min
  - 12/1/2023 Staff education with attestation — 12/1/23

- 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders involving ED CNC/ED leadership oversight.
- Post Medication Administration Assessment Completed as indicated
  - 12/2/2023 Staff education with attestation — 12/2/23
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.
- Order to lab draw-30 minutes
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight.
- Provider response to emergent needs when escalated
  - 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED — 12/2/23
- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
  - 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations — 12/2/23
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
  - 12/2/2023 EKG icon education boost — 12/2/23
  - 12/21/2023 Stethoscope icon — 12/21/23
  - 12/26/2023 Telemetry — 12/26/23
- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS — 12/6/23

- 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign). 12/7/23
- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS 12/6/23
- 12/14/2023 Instituted rapid triage process 12/14/23
- 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. 12/14/23
- 12/9/2024 Trial EMS off-load location set-up
- 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses 12/12/23
- 12/13/2023 Trial EMS off-load process
- 12/14/2023 Tracking and trending of implementation of EKG orders 12/14/23
- 12/20/2023 ED CMU escalation pathway education and implementation 12/20/23
- 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. 12/29/23

Ongoing Actions:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
    - 1/5/2024 direction was given for closed loop communication within 60 minutes of escalated barriers via internal communication tool — 1/5/24
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
    - 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments — 2/1/24
- 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include: — 1/20/24
    - 1/25/2024 Modification of HCG order process to streamline results — 1/25/24
    - 1/30/2024 Structured communication to close loop on identified opportunities for improvement — 1/30/24
    - 1/30/2024 Standardized process to facilitate patient readiness for CT — 1/30/24
- 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS — 1/22/24
- 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours — 1/26/24
- 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding. — 1/30/24
- 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design — 1/30/24
    - 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours — 1/5/24
    - 1/5/2024 Developed triggers for triage escalation and posted at triage desk — 1/5/24
    - 1/5/2024 Assessment/Re- — 1/5/24

assessment policy review

Item	Date
o 1/11/2024 Due diligence walk through with ER Operations and IT	1/11/24
o 1/11/2024 Front-end multidisciplinary team design session	1/11/24
o 1/12/2024 Assessment/Re-assessment policy approved by CNO and Nursing Operations Council	1/12/24
o 1/12/2024 Staff participated in organization and set-up of Critical Supply Room	1/12/24
o 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors	1/12/24
o 1/13/2024 Mock set-up of room 32	1/13/24
o 1/15/2024 Addition of script printer in room 115	1/15/24
o 1/15/2024 IT refresh complete	1/15/24
o 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG	1/16/24
o 1/16/2024 Capital PO issued for 4 portable cardiac monitors	1/16/24
o 1/16/2024 Added additional monitor to Air Traffic Control (ATC) desk to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals	1/16/24
o 1/17-29/2024 Reconfigured front-end area	1/29/24
o 1/17/2024 Per staff request, 3 additional vital sign machines provided	1/17/24
o 1/17/2024 Front-end multidisciplinary team education and roles and responsibilities review	1/17/24
o 1/18/2024 Front-end education of ER providers in January provider meeting by ER Medical Director	1/18/24
o 1/23/2024 Standardization of supply carts	1/23/24
o 1/18/2024 Confirmed Team Health Leadership participation during 1/30 go-live	1/18/24

				Plan of correction	Completion date
				o 1/18/2024 Standardization and escalation of Pharmacy order verification under the MAR education	1/18/24
				o 1/18/2024 Worked with pharmacy to standardize medication storage units	1/18/24
				o 1/18/2024 Added medication refrigerator to the medication storage unit	1/18/24
				o 1/18/2024 Educate staff on defined roles/responsibilities and standard work flow	1/18/24
				o 1/19/2024 Designated location for discharge paperwork and standardized process	1/19/24
				o 1/22/2024 Streamlined laboratory process for COVID, Flu, and RSV to improve timeliness of results	1/22/24
				o 1/23/2024 Confirmed 100% of providers received education on front-end process re-design	1/23/24
				o 1/24/2024 Front-end multidisciplinary team Go/No Go meeting with decision to move forward	1/24/24
				o 1/25/2024 Launch discharge print button to support greater efficiency for the providers to print discharge instructions	1/25/24
				o 1/26/2024 Greet tracker installed in provider area	1/26/24
				o 1/26/2024 Streamlined laboratory process to expedite results for HCG	1/26/24
				o 1/26/2024 6 workstations on wheels (WOW) deployed for provider and CNC documentation efficiency (decreased time from arrival to first clinical order)	1/26/24
				o 1/29/2024 Increased staff efficiency by stocking blood culture bottles in all areas	1/29/24
				o 1/30/2024 Created intake teams to perform MSE, nursing documentation, and implement initial interventions in Internal Processing Area (IPA)	1/30/24
				o 1/30/2024 Deployed 4 portable cardiac monitors	1/30/24

Education:
Education provided to currently working eligible and targeted staff and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals — 12/2/23
- 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight — 12/2/23
- 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals — 12/2/23
- 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol — 12/2/23
- 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment — 12/14/23
- 12/21/2023 ED nursing staff education regarding telemetry order initiation — 12/21/23
- 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process — 12/21/23
- 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff — 12/21/23
- 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway — 12/21/23
- 1/15/2023 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversations with nursing staff completed by education team — 1/15/23

- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front-end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24
- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation — 2/6/24

Monitoring for Compliance/Audit Details:
Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- o Arrival to Triage Times for walk-in and EMS
- o Arrival to EKG order-to-complete per policy/protocol
- o Pain Medication assessment/ reassessment per policy/protocol
- o CIWA assessments per policy/protocol
- o Realtime escalation of patient safety concerns
- o CT order to exam

Sustained Compliance Audits to Ensure POC is Effective:
Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to-completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant EKG order-to-completion per policy/protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ Chief Medical Officer/ACNO/VP Emergency Services

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A 092	Continued From page 78 prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented. 2. Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ________ B. WING ________	C **12/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 092	Continued From page 79 called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A	A 092		

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A 092	Continued From page 80 trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest. 5. Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management. 6. Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the	A 092		

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A 092	Continued From page 81	A 092		

patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing).

7. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff.

8. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED.

9. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900

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A 092 — Continued From page 82 — A 092

(1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment.

10. Patient #26 presented to the ED via EMS on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.

11. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. Record review revealed the patient did not have her vital signs monitored and had no nurse assigned to monitor status or provide care.

A 115 — PATIENT RIGHTS
CFR(s): 482.13 — A 115

A hospital must protect and promote each patient's rights.

Subject of Deficiency – A 115
The hospital staff failed to promote and protect patient's rights by failing to provide a safe environment to Emergency Department patients and failed to obtain consent to treat authorization for pediatric patients. The hospital failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) Pods

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A 115

Continued From page 83

This CONDITION is not met as evidenced by:
Based on policy review, medical record review, Emergency Medical Services (EMS) trip report review, incident report review, observations, environmental risk assessment review and staff and provider interviews, the hospital staff failed to promote and protect patient's rights by failing to provide a safe environment to Emergency Department patients and failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions.

The findings included:

The hospital staff failed to ensure a safe environment for behavioral health patients subject to self-harm in the ED by failing to limit environmental risks in the Emergency Room pods (cluster of rooms in a designated area) used to house Behavioral Health patients awaiting placement (Green Pod and Purple Pod).

Cross refer to 482.13 Patient Rights' Standard: Tag A 0144.

The hospital nursing staff failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions for 1 of 4 sampled pediatric behavioral health patient records reviewed (Patient #75).
Cross refer to 482.13 Patient Rights' Standard:Tag A 0131.

A 115

(cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area.

Mission Hospital ED is a medical ED where care is provided to all patients, including those who may present with behavioral health complaints. The ED at Mission Hospital does not maintain a designated behavioral health area.

Safe Environment Immediate Corrections and System Changes:

Immediate Actions Taken:

- 2/3/24 Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying additional ligature risk items such as the call cord as a potential ligature risk. — 2/3/24
- 2/3/24 Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern. — 2/3/24
- 12/14/23 Increased safety rounding conducted by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks. — 12/14/23

System Changes:

- 2/3/24 The necessity of objects in each room, as well as anything that is specifically located in the rooms, were evaluated and anything not required for direct patient care was removed following an ongoing ligature risk assessment. — 2/3/24
- Ongoing sustained process

commenced in 2022 patients presenting to the emergency department with a behavioral health complaint are screened using the Columbia Suicide Severity and Risk screening process. Patients identified to be at risk will have appropriate risk mitigation strategies through implementation of interventions such as: in-person 1:1, camera observation, and/or q15 minute rounder.

- 2/3/24 Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern. — 2/3/24
- 2/3/24 Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying new ligature risks items such as the call cord as a potential ligature risk. — 2/3/24
- 2/6/24 Education provided to the emergency department staff (RN, PCT, Paramedic, Unit Clerk, ED Leadership) on what is a potential ligature risk to patients — 2/6/24
- Education provided to the Patient Safety Attendants (PSA) regarding what is a potential ligature risk to patients
- 2/6/24 Increased safety rounding conducted by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks

Education Provided to Staff:
2/6/24 ED Huddle start date
2/5/24 PSA Huddle start date

- Emergency department shift huddles are conducted at the start of each employees working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to education 100% of working staff to potential ligature risks to patients. **Education conducted by Charge nurse and or Manager.**
- Patient Safety Attendant education conducted in huddle at the start of each working shift. **Education conducted by PSA team lead to** capture 100% of working staff are educated to potential ligature risks to patients.
- Education in the huddle format is used to capture 1:1 dialogue and

A 131

understanding to include opportunities for teach back and questions.

- Closed loop understanding of huddle information is tracked via staff signed document
- Emergency Department education ligature risk education focused on topics regarding environmental safety, CSSRS, ED expectations, and closed loop communication.
    - Re-circulated CSSRS huddle card which includes displayed icons for ED tracking board for overall care team awareness.

Monitoring for Compliance/Audit Details:

Daily, in person, rounding observations to monitor, track, and ensure that the safety measures are implemented. Patient Safety Rounding audits are used to monitor compliance with ligature risk mitigating factors such as environmental safety and patient safety attendant awareness. Ensuring the POC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements.
1. Patient Safety Rounding audits are conducted by the administrative house supervisor, PSA team lead, or nursing team lead.
Sustained Compliance Audits to Ensure POC is Effective:
·The goal of our audit is to reach a minimum of 90% compliance with the rounding observations. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
Numerator = # of compliant patient safety round observations
Denominator = 70 observation per month
· Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)
2. Education: Daily monitoring and tracking using the huddle tactic to ensure 100% of working staff are educated to potential ligature risks to patients.
See above section Education Provided to staff bullet 1 and 2.
Owner: Chief Nursing Officer/ACNO/VP of Emergency Services

COA Immediate Corrections and System Changes:

- Began daily review on 2/6/24 to ensure all patients under the age of eighteen presenting to the emergency department have appropriate Consent of Admission (COA) completed.
- New education created regarding Consent of Admission (COA) Procedures: Minors and Involuntary Commitment (IVC) to highlight identified areas of opportunity
- New education Consent of Admission: Minors and Involuntary Commitment (IVC) added to general orientation and onboarding
- New education provided to all patient access staff members working in the emergency department regarding COA

Education Provided to Staff:
Date: 2.6.24

- Education regarding COA added to general orientation and onboarding
- Patient Access education for staff working in the emergency department conducted via HealthStream and huddle during working shift. **Education conducted by Patient Access Team Lead, Manager, or PAS Leadership to** capture 100% of working staff are educated to Consent of Admission
- Education in the daily huddle format for patient access staff working in the emergency department (huddles conducted at 12:45 and 10pm) is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

Monitoring for Compliance/Audit Details:
Date: 2.6.24
Utilizing the electronic medical record, pediatric patients who present to the emergency department are reconciled and audited for completion of COA.

			• Daily monitoring of appropriate pediatric emergency department charts for completion of COA. This daily audit is being conducted currently to identify real time fallouts in our process. Sustained Compliance Audits to Ensure POC is Effective: We will conduct audits as outlined below to monitor our sustained compliance. • The goal of our audit is to reach a minimum of 90% compliance with a completed COA. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters. Numerator = # of completed COA Denominator = 70 pediatric emergency department charts a month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) **Owner:** Chief Financial Officer/Director of Patient Access **Subject of Deficiency: A 131** The hospital staff failed to promote and protect patient's rights by failing to obtain consent to treat authorization for pediatric patients.	
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as			

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A 131	Continued From page 84 allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on review of the "Authorization for Nonpsychotropic Medicinal Intervention" form, medical record review and interview, the nursing staff failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions for one (1) of four (4) sampled pediatric behavioral health patient record reviewed. (Patient #75). The findings included: Request for policy revealed the hospital staff advised there was no policy available. The hospital provided a consent form titled "Authorization for Nonpsychotropic Medicinal Intervention" which stated "By signing below I, as the Legally Responsible Person for the minor, _________, do hereby give my consent for the physician to perform medicinal intervention as related to the aforementioned minor. I understand that the physician will be using ________as medication for the purpose of treating the minor for ________. I also understand that I can revoke this consent at any time" and "Authorization for Psychotropic Medicinal Intervention" which stated "By signing below I, as the Legally Responsible Person for the minor, _________, do hereby give my consent for the physician to perform	A 131	<u>**COA Immediate Corrections and System Changes:**</u> • Began daily review to ensure all patients under the age of eighteen presenting to the emergency department have appropriate COA. • New education regarding COA Procedures: Minors and Involuntary Commitment (IVC) to highlight identified areas of opportunity • New education COA: Minors and Involuntary Commitment (IVC) added to general orientation and onboarding • New education provided to all patient access staff members working in the emergency department regarding COA **Education Provided to Staff:** **Date: 2.6.24** • Education regarding consent of admission added to general orientation and onboarding • Patient Access education for staff working in the emergency department conducted via HealthStream and huddle during working shift. **Education conducted by Patient Access Team Lead, Manager, or PAS Leadership to** capture 100% of working staff are educated to COA • Education in the daily huddle format for patient access staff working in the emergency department (huddles conducted at 12:45 and 10pm) is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions. **Monitoring for Compliance/Audit Details:** **Date: 2.6.24** Utilizing the electronic medical record, pediatric patients who present to the	

emergency department are reconciled and audited for completion of COA.

- Daily monitoring of appropriate pediatric emergency department charts for completion of COA. This daily audit is being conducted currently to identify real time fallouts in our process. We will conduct audits as outlined below to monitor our sustained compliance.
- The goal of our audit is to reach a minimum of 90% compliance with a completed COA. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
  Numerator = # of completed COA
  Denominator = 70 pediatric emergency department charts a month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Financial Officer/Director of Patient Access

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A 131	Continued From page 85 psychotropic medicinal intervention as related to the aforementioned minor. I understand that the physician will be using ________as medication for the purpose of treating the minor for ________. I also understand that I can revoke this consent at any time." The forms provided spaces for date/time, legally responsible person signature, relationship, and witness signatures. Review on 12/04/2023 of the closed medical record for Patient #75 revealed a 12-year-old female that presented to the Emergency Department on 06/30/2023 at 2251 by law enforcement with Involuntary Commitment (IVC) paper for assault on therapist and mother. Patient #75 was admitted to inpatient behavioral health services on 07/01/2023 at 2027. Review of the Medication Administration Record (MAR) showed that Patient #75 was administered Zyprexa on 07/01/2023 at 0018, Melatonin and Trazodone at 0045, Prozac, Guanfacine, Lamictal and Quetiapine at 0817, Tylenol at 0913, Benadryl and Zyprexa at 1006 and Sarna Topical Lotion at 1035. Review of the medical record revealed a signed authorization/consent form dated 07/01/2023 at 1614 for the following psychotropic medicinal interventions: Zyprexa (15 hours and 56 minutes after administered), Trazodone (15 hours and 29 minutes after administered), Prozac, Guanfacine, Lamictal and Quetiapine (7 hours and 57 minutes after administered) Zyprexa (6 hours and 8 minutes after administration). Review of the MAR revealed that Patient #75 was administered Benadryl on 07/01/2023 at 1006 with no evidence of a signed authorization/consent form from the parent/guardian. Review of the medical record revealed a signed authorization/consent form dated 07/01/2023 at 1614 for the following	A 131		

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A 131	Continued From page 86 non-psychotropic medicinal interventions: Melatonin (15 hours and 29 minutes after administered), Tylenol (7 hours and 1 minute after administered), and Sarna Topical Lotion (5 hours and 39 minutes after administered). Interview on 12/06/2023 at 1520 with RN #84 revealed that consent forms should be obtained from the parent/legal guardian prior to administration of psychotropic and/or non-psychotropic medications to a minor.	A 131		
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 observations, review of the "Environmental Risk Assessment for Suicide Prevention" form, and staff and provider interviews, the hospital failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) Pods (cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area. The findings included: Observation on 11/13/2023 at 1150 during tour of the emergency department (ED) revealed Green Pod had twelve patient care rooms, eight of which had adolescent behavioral health patients in them. Three of the eight patients had a sitter at	A 144	**Subject of Deficiency: A 144** The hospital failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) Pods (cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area. Mission Hospital ED is a medical ED where care is provided to all patients, including those who may present with behavioral health complaints. The ED at Mission Hospital does not maintain a designated behavioral health area. **Policy:** 1PC.PSY.0102 – Patients At Risk for Suicide in Non-BH Settings **<u>Safe Environment Immediate Corrections and System Changes:</u>** **Immediate Actions Taken:** • Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying additional ligature risks items such as the call cord as a potential ligature risk. • Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern. • Increased safety rounding conducted	

by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks

System Changes:

- The necessity of objects in each room, as well as anything that is specifically located in the rooms, were evaluated and anything not required for direct patient care was removed following an ongoing ligature risk assessment.
- Patients presenting to the emergency department with a behavioral health complaint are screened using the Columbia Suicide Severity and Risk (CSSRS) screening process. Patients identified to be at risk will have appropriate risk mitigation strategies through implementation of interventions such as: in-person 1:1, camera observation, and/or q15 minute rounder.
- Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern.
- Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying additional ligature risks items such as the call cord as a potential ligature risk.
- Education provided to the emergency department staff (RN, PCT, Paramedic, Unit Clerk, ED Leadership) on what is a potential ligature risk to patients
- Education provided to the Patient Safety Attendants (PSA) regarding what is a potential ligature risk to patients
- Increased safety rounding conducted by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks

Education Provided to Staff:
2/6/24 ED Huddle start date
2/5/24 PSA Huddle start date

- Emergency department shift huddles are conducted at the start of each employees working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic

used to education 100% of working staff to potential ligature risks to patients. **Education conducted by Charge nurse and or Manager.**

- Patient Safety Attendant education conducted in huddle at the start of each working shift. **Education conducted by PSA team lead to** capture 100% of working staff are educated to potential ligature risks to patients.
- Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.
- Closed loop understanding of huddle information is tracked via staff signed document
- Emergency Department education ligature risk education focused on topics regarding environmental safety, CSSRS, ED expectations, and closed loop communication.
    - Re-circulated CSSRS huddle card which includes displayed icons for ED tracking board for overall care team awareness.

Monitoring for Compliance/<u>Audit Details:</u>

Daily, in person, rounding observations to monitor, track, and ensure that the safety measures are implemented. Patient Safety Rounding audits are used to monitor compliance with ligature risk mitigating factors such as environmental safety and patient safety attendant awareness. Ensuring the POC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements.

1. Patient Safety Rounding audits are conducted by the administrative house supervisor, PSA team lead, or nursing team lead:
· The goal of our audit is to reach a minimum of 90% compliance with the rounding observations. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
Numerator = # of compliant observations
Denominator = 70 observation per month
· Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

2. Education: Daily monitoring and tracking using the huddle tactic to ensure 100% of working staff are educated to potential ligature risks to patients.
See above section Education Provided to staff bullet 1 and 2.
Owner: Chief Nursing Officer/ACNO/VP of Emergency Services

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 144	Continued From page 87 the doorway of their room (Room 78, 80, and 83). Observation revealed all eight behavioral health patients had a corded call bell. Tour of the Purple Pod revealed a twelve-patient care room unit with eleven behavioral health adult patients in them. Observation revealed all eleven patients had corded call bells. There were two sitters for two of the eleven patients (Room 44 and 48). There were three rooms in the Purple Pod that had Hoyer lifts (device to assist with moving and lifting a patient who cannot move themselves) on the ceiling (Rooms 37, 42, and 45). The twelve rooms and the bathrooms in the Purple Pod had rectangle shaped hook(s) behind the door that were not breakaway hooks. Staffing consisted of two Registered Nurses and a Rover (a Patient Safety Attendant assigned to round every fifteen minutes on the patients in the unit). Observation on 11/15/2023 at 1315 in the Purple Pod revealed eight behavioral health adult patients. The Rover (Patient Safety Attendant assigned to perform every fifteen-minute checks) took a corded telephone into Room 46 and left the room. The patient in the room did not have a virtual sitter nor a one-to-one sitter while having the corded telephone. Observation on 11/30/2023 at 0947 during tour revealed there were four patients in the Green Pod with corded call bells. There were no sitters with the four patients. The patient in room 77 had a hospital bed with a fitted sheet on the bed instead of the behavioral health safe sheets (linen that is designed to not hold tied knots). Observation revealed Rooms 73 and 82 had bathrooms within the patient rooms. Each bathroom contained safety handrails that you could tie something completely around the rail,	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 144	Continued From page 88	A 144		

normal toilets, regular faucets on the sinks, and regular mirrors. Observation during tour of the Purple Pod revealed the Pod had been "flipped" back for non-behavioral health patients.

On 11/30/2023 a review of the "Environmental Risk Assessment for Suicide Prevention" performed on 09/08/2023 revealed any ligature risk identified were listed as being mitigated by monitoring needs that were put in place as identified by the suicide risk scores.

Interview on 11/27/2023 at 1500 with Acting Chief Nursing Officer (ACNO) #47 revealed that all the rooms are ED rooms and all the Pods in the ED were used for any type of ED patients. A behavioral health patient could be placed anywhere in the ED not only in the Blue Pod, or the current overflow Pods, Green and Purple, that were currently used to house overflow behavioral health patients. ACNO #47 stated that all behavioral health patients get a C-SSRS (Columbia Suicide Severity Rating Scale- assessment tool used to evaluate a patient's suicidal ideation and behavior) score performed by a nurse. The C-SSRS score was used to determine if a patient was low, moderate, or high risk (a yes answer on key questions within the assessment would increase the score from low to moderate or high risk). Interview revealed a medical provider would perform their assessment and their determination trumps the score of the nurse. Interview revealed the risk of self-harm was mitigated based on the patients' C-SSRS score, if a patient was Low risk, they were rounded on every fifteen minutes by the Rounder, if the patient was Moderate risk, they got a virtual sitter, and if the patient was High risk, they got a one-to-one sitter.

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 144	Continued From page 89	A 144		

Interview on 11/27/2023 at 1504 with Nurse Vice President for ED Services #20 revealed the risk of self-harm were mitigated based on the patients' C-SSRS score. Interview revealed if a patient was Low risk, they were rounded on every fifteen minutes by the Rounder, if the patient was Moderate risk, they got a virtual sitter, and if the patient was High risk, they got a one-to-one sitter. The nurse would check on the patient as they deem appropriate and perform safety checks on every patient in the Pod every hour.

Interview on 11/28/2023 at 1306 with COO (Chief Operating Officer) #50 and ACNO #47 revealed nursing took safety steps for overflow areas of behavioral health patients in the Green and Purple Pods. The staff members reported that nursing checked off in the electronic medical record that they have validated the rooms were safe for the patient. The hospital saw an increase in the number of behavioral health patients, so when the new Pediatric ED area opened in September of 2023, the space that was previously used for pediatrics (identified as the Purple Pod) became an overflow/holding area for behavioral health patients. Interview revealed the last known time a medical ED patient was in the Purple Pod (a pediatric patient) was September 26, 2023 (after the environmental risk assessment for suicide prevention was performed on September 8, 2023). Interview revealed safety for behavioral health patients in the Green Pod based on their C-SSRS score would be every fifteen-minute check by the Rounder or the virtual sitter, or the one-to-one sitter. Depending on the volume of patients and their acuity (high risk, elopement risk, patients that wander) there would be either one or two Rounders in the Pod.

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 144	Continued From page 90 Interview revealed if the volume was low, the hospital may need to and can put an adult patient in the Green Pod with the adolescent behavioral health patients. Interview revealed that based on the C-SSRS score, they would put in place mitigators (staff to monitor) to assure safety for patients. The staff member stated they do not monitor and cannot pull the data to determine the last time there were both pediatric/adolescent and adult patients in the Green Pod at the same time. Interview revealed the staff do not monitor when the Pods are used as behavioral health only patients versus medical ED patients, nor how frequently they are being flipped back and forth. It was reported that the staff mitigate the risk of harm in the room space down to what is deemed appropriate by removing trash cans, suction, cords, and make sure the beds have a behavioral health approved sheet on it. Interview revealed the corded call bell was not removed from the room as it is the patient's way of calling staff if they need something and it operates the television in the room. Mitigating factors (every fifteen-minute check, virtual sitter, or one-to-one sitter) are put in place based on the C-SSRS score. The staff member reported corded telephones are used if the patient wants to make a telephone call, and that it was a patient's right to make telephone calls. If the patient was high risk, have a one-to-one sitter with them when they have the telephone, if they were a moderate risk they have a virtual sitter with them, and the low risk has an every fifteen-minute check done by the Rounder. The "nurses are really in tune with the patients" in behavioral health. Interview revealed the nurses rotate throughout the ED and were not always working in the pods that have behavioral health only patients in them. Interview revealed the Green Pod and Purple Pods were	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING _______ B. WING _______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 144	Continued From page 91 not psych friendly. Mitigating factors were put in place such as every fifteen-minute check, virtual sitters, or one-to-one sitters based off the patients C-SSRS score. Interview on 11/30/2023 at 1532 with Manager #51 and Manager #49, that performed the Suicide Risk Environmental Assessment on 09/08/2023, revealed the Green Pod and Purple Pod areas were a medical ED and not a Behavioral Health unit. Behavioral Health patients could be in any area of the ED. The staff reported that all risks for behavioral patients in the ED could be mitigated by every fifteen-minute observation, a virtual sitter, or a one-to-one sitter. The staff stated, the call bell cords break away from the wall if, for instance, someone pulled on it or put too much pressure on it. It was stated that they did not look at the cord itself as a risk used for hanging or self-harm, just that it could break away from the wall. Telephone cords were not evaluated on the risk assessment that was performed, and staff reported they were not aware that Behavioral Health patients were given a telephone with cords in their rooms. The interview revealed that a risk assessment was done for the entire ED on September 08, 2023. Interview revealed the staff conducting the assessment did not go in every room in the ED when they did the Environmental Risk Assessment for Suicidal Prevention. The staff members stated that they did not go back and look at the Purple Pod that was converted over to behavioral health holding/overflow after the pediatric patients were moved to the new pediatric ED.	A 144		
A 263	QAPI CFR(s): 482.21	A 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 263

Continued From page 92

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:
Based on policy review, Quality Performance Improvement Plan review, medical record review, incident report reviews, pharmacy unit inspection review, and staff interviews, hospital leadership failed to ensure adverse events were documented, tracked, trended, and analyzed in order to implement preventive actions and identify success of actions taken.

The findings included:

1. The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for seven (7) of 94 sampled patient records reviewed. (Patient #'s 58, 27, 59, 50, 15, 13, and 2).

Cross refer to §482.21 Standard: QAPI Quality

A 263

Subject of Deficiency: A 263
Hospital leadership failed to ensure adverse events were documented, tracked, trended, and analyzed in order to implement preventive actions and identify success of actions taken.

Plan of Correction:

Actions:

- Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety.
- Daily report out of patient safety reports at Safety Huddle
- Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration
- Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports
- Quality/Patient Safety/Risk oversight of patient safety reports closure
- Routine patient safety reports report emailed to hospital leadership for review of reported events from past 24 hours
- Routine review of patient safety reports by Hospital Leadership and members of the Quality/Patient Safety/Risk team
    - Facilitation of early event identification for timely investigation/action as appropriate
    - Monitor for trends
    - Ensures routing of events to appropriate parties for review
        - Provider-related concerns and events escalated to service line leadership and/or peer review as

appropriate
- All mortality events captured in daily mortality report being reviewed by CMO/ACMO

- Intense Analysis/SEAs
  - Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team as appropriate
  - Lessons learned and best practices shared via case studies at monthly Patient Safety Committee

Monitor for Compliance:
- Monthly reporting in Quality Council
- Reporting through Board of Trustees (BOT)

Owner: Chief Medical Officer/ACMO

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A 263	Continued From page 93 Improvement Activities: Tag A 0286. 2. The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action for 7 of 94 sampled patients reviewed. (Patient #'s 58, 27, 59, 50, 15, 13 and and 2). Cross refer to §482.21 Standard: QAPI Quality Improvement Activities: Tag A 0309.	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and	A 286	**Subject of Deficiency: A 286** The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action. **Plan of Correction:** **Education:** **12.3.23 Healthstream online annual safety event reporting mandatory education completed for all staff.** **Actions:** • Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety. • Daily reporting of patient safety reports activity at Safety Huddle • Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration • Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports • Quality/Patient Safety/Risk oversight of patient safety reports closure • Routine patient safety reports emailed to hospital leadership for review of reported events from past 24 hours • Routine review of patient safety reports	

by Hospital Leadership and members of the Quality/Patient Safety/Risk team

Facilitation of early event identification for timely
- investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
  - Provider-related concerns and events escalated to service line leadership and/or peer review as appropriate
  - Ensure that any mortality events are also captured in daily mortality report being reviewed by CMO/ACMO

- Intense Analysis/SEAs
  - Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team as appropriate
  - Lessons learned and best practices shared via case studies at monthly Patient Safety Committee

Monitor for Compliance:
- Monthly reporting via Patient Safety Committee
- Monthly reporting via Quality Council
- Reporting through Board of Trustees (BOT)

Owner: Chief Medical Officer/ACMO

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A 286	Continued From page 94 accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on policy review, medical record review, incident report review, pharmacy unit inspection review, personnel file review, hospital document review and staff and physician interviews, the hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for seven (7) of 94 sampled patients reviewed (Patient #'s 58, 27, 59, 50, 15, 13 and 2) The findings included: Review of the hospital policy titled "Event and Close Call Reporting" revised 10/13/2022 revealed "... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems ... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems... This policy applies to services provided by (Hospital Corporate Name) staff members in each of these settings: ... *Inpatient services, including acute care and behavioral health, critical access hospitals, and other related services * Emergency Departments (ED) * Hospital-based outpatient department or ambulatory services, including but not limited to behavioral health services and Independent Diagnostic Testing Facilities ... *Physician practices or clinics that may include rural health clinics or federally qualified health care centers ... NC Division Clarification ... In addition to the roles listed in the policy, the	A 286		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 286	Continued From page 95 Directors of Quality and Patient Safety and/or Administrative Quality Directors are also responsible for oversight of this process ... Escalation to Leadership ..." 1. Medical record review revealed Patient #58 had a witnessed fall on 04/26/2023 following abdominal surgery for a gun shot wound. A CT (cat scan) of the Abdomen and Liver on 04/26/2023 showed changes to a liver hematoma (clotted blood within the tissues) from the previous CT study on 04/25/2023. Patient #58 was moved to ICU (intensive care unit) for closer monitoring, and Interventional Radiology was consulted to rule out active bleeding. On 04/27/2023 Patient #58's hemoglobin dropped from 13.2 to 7.3 [6.0] and he received 2 units of red blood cells, and he underwent CT Angiogram and found no active bleed. Request for an event report on 12/05/2023 revealed there was not one available for Patient #58 after a witnessed fall, that required interventions. Telephone interview on 12/06/2023 at 1332 with RN #95 revealed she remembered the patient. Interview revealed "...he said he was going to pass out. We assisted him back to the bed after the fall and called a rapid response. I called the doctor. I didn't remember to complete a report, it was not quite a fall. I guided him to the bed, and another nurse picked his legs up onto the bed..." Interview revealed Patient #58 had a witnessed fall, and an event report was not completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Interview on 12/06/2023 at 1409 with the Charge	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 286	Continued From page 96 Nurse, RN #96 revealed "...if a patient falls, we complete a (named) an incident report..." Interview revealed for witnessed falls an incident report should be completed. Interview revealed an event report should have been completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Telephone interview on 12/07/2023 at 0906 with MD #94 revealed he remembered the patient. Interview revealed "...he had a traumatic liver injury it would not be surprising to have a re-bleed, it required packing, and hemorrhage control. He did get an CT and have an interventional radiology angiography procedure after the event to ensure he didn't have an active bleed...It's impossible to tell...the fall did not extend an injury or stay at the hospital..." Interview revealed Patient #58 did have interventions after the fall on 04/26/2023 to ensure he had no active bleeding. Interview revealed hospital policy was not followed for event reporting for Patient #58 after a witnessed fall. 2. Review on 12/05/2023 of the policy Facility Event and Close Call Reporting Policy and Procedure, with effective date 04/01/2022 revealed "...PURPOSE: This policy is intended to minimize risks to patients, ...through the development and implementation of an event and close call reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report events and close calls to the Patient Safety Director, Risk Manager, or designee. Furthermore, this policy is intended to mitigate risks and improve quality of services by outlining the processes for factual reporting of	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 286	Continued From page 97 events, close calls, and unsafe situations. POLICY: Facility staff will provide the needed data elements through a formal, documented event reporting system. Event reports should be completed as soon as possible after the event, but no later than the end of the shift...X. Fair and Accountable Reporting Culture...B. The responsibility for reporting an event or close call rests with any person who witnesses, discovers, or has direct knowledge of that event or close call..." Medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported abdominal pain level of 10 of 10, and nausea and vomiting. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was not medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay in pain management, STAT lab work, STAT CT, and physician orders as prescribed. Request for a Patient Safety Report (Event Report) revealed there was not one available. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed patients had delays in receiving pain management, STAT lab work and completion of physician orders in the ED waiting room. Interview revealed an event report was not completed for Patient #27.	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 286	Continued From page 98 Interview on 11/17/2023 at 1102 with NP #39 revealed she had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview revealed an incident report should have been completed for Patient #27. Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to place orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not receive pain management, STAT lab work, STAT CT, and physician orders as prescribed. Interview revealed an incident report should have been completed for Patient #27. 3. Closed medical record review revealed on 3/4/2023, Patient #59 was admitted to the oncology unit and received a diagnosis of acute myeloid leukemia. Per physician orders, treatment for acute myeloid leukemia included Dacogen (intravenous chemotherapy medication) and Venetoclax (oral oncology medication). On 3/17/2023, the patient was infused Dacogen after two (2) [oncology nurses] verified the medication. Further review revealed on 3/18/2023, an Oncologist documented that the patient received an expired dose of Dacogen. The incident report for Patient #59's medication administration of the expired dose of Dacogen, was requested on 12/7/2023 at 11:00 AM from the Director of Quality. No incident report was	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 99 provided. Upon inquiry for pharmacy unit inspections from March 2023 through November 2023 revealed there had only been one inspection documented on 5/16/2023. Interview on 12/6/2023 at approximately 8:45 AM with the oncology pharmacist revealed oncology patients could be located on any unit within the hospital, in which case, the oncology medication would be delivered from outpatient infusion pharmacy to the oncology unit. The oncology nurse(s) would be responsible for going to the perspective unit(s) for the administration (intravenous and/or oral) of the medication. The pharmacist was unaware that an oncology patient was administered an expired dose of Dacogen. Interview on 12/7/2023 at approximately 10:30 AM with oncology staff revealed that Patient #59 declined the first dose of Dacogen, which could have resulted in the administration of an expired medication. Interview on 12/7/2023 at 11:00 AM with the Director of Quality revealed the Oncologist failed to enter an incident report and/or failed to speak to anyone regarding the administration of an expired dose of Dacogen to Patient #59 that occurred 3/17/2023. Interview on 12/7/2023 at 1:51 PM with the Oncology Unit Manager (OUM) revealed in April 2023 the oncology unit adopted a more detailed treatment administration checklist to assist the oncology nurses and the pharmacy department. The OUM further indicated she could not speak to the effectiveness of the updated checklist	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 286	Continued From page 100	A 286		

because no audits had been performed.

Telephone interview on 12/8/2023 at 3:00 PM with the Oncologist revealed providers were made aware after-the-fact of any problems or concerns. As related to the administration of expired medication to a patient, the oncologist revealed, efficacy should be the main concern which falls upon the pharmacy department and was pretty sure this was what happened in the case of Patient #59. Further inquiry revealed that since the hospital joined [name of organization], the oncology unit lost valuable nurses which led to the hiring of new/inexperienced staff, and increased use of travel staff. The changes in staff led to an increase in errors, especially with neutropenic patients, which resulted in a degradation in care. Additionally, in the past oncology patients were directly admitted to the oncology unit without emergency department presentation. Now, oncology patients were admitted through the emergency department secondary to closure of transfers, which put the oncology patients at an increased risk for infection. Additionally, the unit no longer admitted complex cases of oncology patients because those cases were referred to other hospitals. Further interview revealed pharmacy errors increased secondary to the loss of experienced oncologist pharmacists. The interview concluded with the aforementioned concerns were voiced to the Medical Director for the oncology service line in which there were no notifications or any observations of changes.
4. Review of the closed medical record for Patient #50 revealed a 21-year-old female presented to the Emergency Department (ED) via law enforcement under IVC (involuntary commitment) for a "Psychiatric screening exam; Behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 286	Continued From page 101 health concern." Review of the Provider Note dated 05/04/2023 at 1640 revealed "... patient presents with IVC paperwork and recent behavior concerning for danger to others in particular ... I will have behavioral health services see the patient ..." Review of the Initial Psychiatric Evaluation dated 05/06/2023 at 0531 revealed "The patient is a 21 yo (year old) female with h/o (history of) autism and mild intellectual disability, who was brought to the ED under IVC due to increasingly aggressive behavior. The IVC paperwork reports (sic) that the patient has been going around the neighborhood with a hammer. She has done thoughtless things such as covering her father's eyes with his hat while driving and then kicking him. The (sic) patient's behavior has been escalating since she could no longer participate in her programs during COVID 19 (pandemic). Instead of going to a group home, she was d/c (discharged) home from her last program. She has been increasingly irritable since she is swinging to calm herself down and has demonstarted (sic) dangerous behaviors ... Nursing reports pt (patient) became unexpectedly agitated this AM (morning), pulled nurse and sitter's hair after being asked if her ears hurt (she was pulling at them). She received 5 mg (milligrams) Versed (medication to help you relax) at time of arrival to the ED yesteay (sic) afternoon, but otherwise no PRN (as needed) medication. She has not required restraint ... She is mostly mute (refraining from speech), although sometimes echolalic (repeat others) and echopraxic (involuntary copying of another person's actions or movements). She waves when I wave. Says 'hello' when I say hello, and 'happy' when I ask if she is happy'(sic) ... Suggested plan; Uphold the IVC for now; observe the patient for the next 24-48 hours (sic); if the	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 102 patient is stabilized, she can be discharged home or to a new placement, if one is available." Review of the Mental Health Contact Note dated 05/08/2023 at 1017 revealed "... reached out to Pt's mother, ..., and informed her that Pt was seen by Psychiatrist who is recommending discharge due to concerns of Pt safety on this unit, her aggressive behaviors w/ (with) other Pt's ..." Review of the Nurse Note dated 05/29/2023 at 0855 revealed "... This was the third time pt had attacked the hair of a sitter." Review of the Provider Note dated 05/29/2023 at 1007 revealed "...Patient was triggered by her sitter and attacked her this morning jumping on top of her and grabbing her hair ... Nursing staff reports this is the third sitter she is intact (sic) in the past 2 days ..." Review of the Nurse Note dated 06/10/2023 at 1920 revealed "Earlier today ... had multiple aggressive acts towards me, the first was when she spit on me as I was handing her a snack in the BHU (behavioral health unit) ... The second aggressive act came hours later when she saw me in the hall and came towards me. I attempted to walk away but she ran towards me, screaming and reaching for my face. She was able to pull the mask off my face but I restrained her hands and took several steps back, when she came after me again screaming and tearing at my head and face. I restrained her hands again and walked her back into her room towards her bed. As I let go and backed up ... leaned on her bed and kicked me in the chest with all her force ... I don't intend to escalate this matter any further and have explained the entire situation to the psych clinician." Mental Health Contact Note dated 06/18/2023 at 2100 revealed "... sitting in BHU intake office and heard yelling. Pt seen ... on camera gripping a male pt hair in ... hallway bed. Pt was standing over male pt's hallbed (sic), hand	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 103 in male pt's hair shaking pt's head around. Male pt was yelling ... immediately came out of BHU intake office, pt ran back towards her room into her bed. Male pt was visibly upset and yelling at pt in her room ..." Nurse Note dated 06/18/2023 at 2130 revealed "Pt. ran out of her room and pulled hair/hit another pt who was in a hall bed. After getting loose the pt. ran after her back in to her room, a BERT (behavioral health emergency) was called, physician, RNs, psych clinicians, and security all responded. The pt who was attacked aggressively was shouting, punching the walls, and hitting her bed. We were able to de-escalate the situation and both pts. We moved the second pt. to a differed pod in his own room so he would feel safe. It is unsure if (Patient #50) was hit while he was hitting her bed, physician did an assessment and she has no obvious injuries or marks. Pts are both settled in separate areas now." Review of the medical record revealed Patient #50 was discharged to a facility on 06/20/2023 at 1659. Review on 12/05/2023 of the incident/variance reports provided regarding Patient #50 revealed there were no incident/variance reports for the incident on 05/29/2023 nor on 06/10/2023 to correspond with the incidents described in the medical record notes. There were incidents dated 05/27/2023 and 06/18/2023. Telephone interview on 12/06/2023 at 1400 with PSA #48 revealed she remembered Patient #50 and had to push her distress alarm button when caring for Patient #50. Interview revealed there had been several incidents involving Patient #50 pulling staff hair, attacking staff or other patients. Interview revealed PSA #18 had submitted incident/variance reports herself regarding more	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 104	A 286		

than one incident with Patient #50. Interview revealed there was a male patient in her room one time. PSA #18 could not remember the details about this incident, however confirmed she had filled out an incident report. PSA #18 stated there was a time when Patient #50 kissed another patient and an incident report should have been filled out about that.

Interview on 12/06/2023 at 1500 with Director #82 revealed she only had four incidents/variances for Patient #50. Three of the four were dated 2022 and only one from 2023. Director #82 did not have the incident/variance provided to this surveyor dated 05/27/2023. Interview revealed the person entering the incident/variance did not enter the medical record number and Director #20 searched by the medical record number. Interview revealed it is hard to find incidents/variances if the medical record number is not entered so the information will pull across the system and make it easier to find. Interview revealed they can search by name however if the name is misspelled there would be problems finding any incidents/variances that were entered. Director #82 requested more time to research to see if there were more incidents/variances. At time of exit from facility on 12/09/2023 at 1600, Director #82 had not provided any additional information to this surveyor regarding additional incidents/variances for Patient #50.

5. Closed medical record review of Patient #15 revealed a 21 year old male admitted on 08/14/2023 with abdominal pain. Record review revealed the patient had laparoscopic converted to open total abdominal colectomy (remove all or part of colon) with end ileostomy (stoma-opening in abdomen surgically created) on 08/27/2023 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 286	Continued From page 105	A 286		

ulcerative colitis. Record review revealed on 08/27/2023 at 1117 a ketamine drip was ordered stat (urgent). Record review revealed the patient arrived in PACU (post anesthesia care unit) at 1120. Patient transferred to floor (unit) at 1420. Record review revealed ketamine was started at 1448 on the unit. Patient returned to PACU at 1515 for ketamine drip. Review of nursing note on 08/27/2023 at 1526 revealed "Ketamine gtt (drip) sent to floor from pharmacy rather than to PACU. Patient arrived on the unit from PACU without ketamine gtt started. Notified (named) CNC (clinical nurse coordinator) and called to PACU nurse for patient to be transferred back to PACU for ketamine gtt initiation and required monitoring." Review of nursing note on 08/27/2023 at 1656 revealed "Pt (patient) transferred to floor after report called to RN (registered nurse). PT was ordered Ketamine and the pharmacy sent the medication to the nursing unit instead of PACU. RN agreed in report to start ketamine on pt arrival to floor, since the ketamine was on the unit. Pt later brought back to pacu when nurse became aware that she was not cleared by hospital regulations to start the ketamine gtt."

Review of a ketamine drip timeline document revealed Ketamine drip ordered at 1117. The order was verified by pharmacy at 1140, but the label was not printed. Missing medication request sent by the RN at 1228, high priority with comment "please bring to PACU pod 2 bay 9". Medication request was accepted by pharmacy at 1243 and label was printed. Label stated A3W/A336 as location. Medication hand delivered to staff and signed as received by the named RN. Ketamine drip documented as initiated at 1448. Review of ketamine delivery signature sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 286	Continued From page 106	A 286		

revealed no time of acceptance documented.

Review of the incident/variance reports provided regarding Patient #15 revealed there were no incident/variance reports for the incident on 08/27/2023 to correspond with the incident described in the medical record notes.

Interview on 11/16/2023 at 1045 with RPH #87 revealed medications are sent to locations based on the patient's location in the medical record. Interview revealed when patients are in PACU the pharmacy staff rely on nursing to put in a missing medication request in order to get the drug to the correct location.

Interview on 11/16/2023 at 1230 with PA #90 who ordered the drip revealed the drip was supposed to be initiated as soon as possible. Interview revealed the ketamine drip should have been started before the patient went to the floor. Interview revealed "the periop phase can be tricky and the patient's location does not populate automatically."

Interview on 11/16/2023 at 1421 with RN #88 revealed the PACU staff had waited for hours for the pharmacy to fill the order. Interview revealed the medication had been delivered to the floor and not to PACU. Interview revealed pharmacy was called several times to inquire about medication, "so we thought they knew that the patient was in PACU since we kept calling."

Interview on 11/17/2023 with NM #89 revealed ketamine drips are not done on the unit, they should be initiated on a higher level of care unit. Interview revealed the unit and pharmacy staff received education on which units can not initiate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 107	A 286		

the ketamine drip. Interview revealed the education was in 12/2022. Interview revealed more education would be given to staff.

Interview on 11/27/2023 at 1540 with RPH #79 revealed the nursing staff would put in a medication request when they are ready for the medication to be prepared. The RN has to put in the location of the patient with the medication request. Interview revealed the pharmacy staff that processed the label may not be the same staff member that delivered the order, and the patient's location may not have been communicated to the delivery technician. Interview revealed the delivery technician would then go by the location that was printed on the label.

Request to interview a floor nurse revealed not available for interview.

Request to interview the unit CNC revealed not available for interview.

6. Review of a policy titled "Physiologic Monitoring-Cardiac Telemetry Monitoring..." with a revision date of 08/14/2023, revealed "Internal (lateral) transfers within the (named hospital). C. Patients transferring to non-ICU (Intensive care unit) units with continuous ECG (Electrocardiogram) orders will transport on continuous ECG. 2. The receiving RN will notify CMU (cardiac monitoring unit) with patient name/MRN (medical record number), room being transferred to and telemetry box being assigned."

Closed medical review on of Patient #13 revealed a 76 year old male admitted on 08/19/2023 at 1430 for hypertension (high blood pressure) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 108 Intracranial hemorrhage (brain bleed). Review of RN #53's note written on 08/25/2023 at 1750 revealed "Transferred to Floor. Transfer Report Given to (RN #54). Transport equipment: Monitor. Mode: Wheelchair." On 08/25/2023 at 1934, Patient #13 was transferred to a stepdown unit. Review on 11/15/2023 of an incident report written by CMU supervisor #52 revealed (Patient #13)" had active 48 hr (hour) tele (telemetry) orders from 08.24.2023 at 1348 but were (sic) not being monitored." Review of telemetry strips failed to reveal a telemetry strip for evening hours of 08/25/2023. Review revealed Patient #13 was not monitored by telemetry for 6 hours. Review of a Safety Event Timeline dated 08/29/2023 at 1408 from Manager #56 from Floor A revealed "Status: Assigned to Manager #55, Manager of Floor B (sending floor manager)." Review revealed on "08/31/2023 at 1234, Status: Assigned. Closed." Review revealed no further documentation from Manager #55. Review revealed no documentation of the investigation of the Patient #13 without telemetry monitoring. Interview on 11/15/2023 at 1605 with CMU supervisor #52 revealed a daily audit is conducted at 0100 and 1300 of telemetry patients to ensure patients are being monitored as ordered. Interview revealed Patient #13 was found to have an order for telemetry but was not being monitored. Patient #13 had not been monitored since transfer to another floor on 08/25/2023 at 1934. Interview revealed Patient #13 was placed on telemetry on 08/26/2023 at 0139, 6 hours and 5 minutes after transfer to the floor. Interview on 11/28/2023 at 1234 of RN #54	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 109	A 286		

revealed no recollection of Patient #13 or details of the transfer. Interview revealed RN #54 had not been interviewed regarding the incident of Patient #13.

Interview on 11/28/2023 at 1633 of RN #53 revealed no recollection of Patient #13 or details of the transfer.

Interview on 11/30/2023 at 1645 with Risk Manager #58 revealed "incidents should be reviewed and escalated to the department leaders. There should be notes from the manager."

Interview of Manager #55 was not obtained due to no longer employed.

Patient #13 was transferred to Floor B with telemetry orders. After 6 hours, Patient #13 was discovered without telemetry. There was no review of the incident from the management of the sending floor or risk management.

7. Medical record review on 11/14/2023 of Patient #2 revealed the patient arrived to the Emergency Department on 10/17/2023. Review of the EMS Patient Care Record revealed EMS received a call at 1654, arrived to Patient #2's home at 1720 and transported the patient to the hospital, arriving at 1748. EMS documented they transferred care of the patient to the hospital at 1907, 1 hour 19 minutes later. Prior to the transfer of care, review revealed EMS continued monitoring Patient #2. A note in the EMS record indicated "Turn Around Delays.....ED Overcrowding/ Transfer of Care......."

The hospital ED record review revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 286	Continued From page 110	A 286		

patient arrived at 1753 via EMS, with complaints of chest pain, shortness of breath, and syncope. Patient #2 was noted as evaluated by a provider at 1845 (52 minutes after arrival) and triaged by a RN at 1900 (1 hour, 7 minutes after arrival). An EKG was completed at 1905 (1 hour 12 minutes after arrival) and labs, including troponin, were drawn at 1920 (1 hour 27 minutes after arrival). Record review revealed a delay in the hospital accepting the patient from EMS, triaging and initiating care to the patient, including an EKG and labs. Patient #2 went into cardiac arrest at 1953 (2 hours after arrival) and subsequently expired after failed resuscitation attempts.

Review of a document received from the hospital related to this patient, on 11/16/2023, revealed it was not dated or timed and was not signed. Document review revealed the following statement: "I have reviewed this case and the initial presentation, the timing on the workup, the findings and escalation were all appropriate and met standard of care. The patient arrived at 1753, was roomed at 1830 and was seen by a clinician at 1845 the patient coded at 19:53 and had a time of death at 22024 (sic) all of which occurred while in a room. The EKG was reviewed by the initial clinician and reported in the chart. The patient coded at 1953 and Dr. (Name) was called to the Code. During the code Dr. (Name) has documented that the patient had brief return of consciousness with the ongoing CPR. During this time he began reviewing the workup and the EKG, which was handed to him at 2002. It was read as sinus rhythm with a PVC and a 4 beat run of non-sustained ventricular tachycardia. He signed this EKG at this time 2002, the code was continued for another 22 minutes before time of death." There were no other notations on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 286	Continued From page 111	A 286		

received document including no identification of who completed it or when. The document did not identify any areas of concern. There was no documented review of the timing of triage or implementation of orders. Additional information on the document was requested on 11/17/2023. No updated information was received.

Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed EMS was able to given hand-off report to a nurse at 1907 (over an hour after arrival). Interview revealed wait times for EMS to hand-off patients had recently gotten more common.

Telephone interview with RN #66, on 11/16/2023 at 0938, revealed that until patients were in a room and care handed-off from EMS, they were "counting on EMS to care for (the patients). ...."

Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the goal for screening evaluations was 20 minutes from arrival.

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. MD #72 acknowledged a delay with Patient #2. Interview revealed the physician was not aware if there was a review of the case.

Review of documents received did not reveal an incident report. Review of findings and document provided revealed the hospital failed to identify and evaluate delays in accepting, triaging and initiating care and treatment for a patient presenting via EMS with chest pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

A 309 Continued From page 112

A 309 QAPI EXECUTIVE RESPONSIBILITIES
CFR(s): 482.21(e)(1), (e)(2), (e)(5)

The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:

1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained .
(2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.
(5) That the determination of the number of distinct improvement projects is conducted annually.

This STANDARD is not met as evidenced by:
Based on policy review, Quality Improvement Performance Plan review, medical record review, incident report review, pharmacy unit inspection review, personnel file review, hospital document review and staff and physician interviews, the hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action for seven (7) of 94 sampled patients reviewed (Patient#'s 58, 27, 59, 50, 15,

A 309

Subject of Deficiency: A 309

The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action.

Plan of Correction:

Actions:

- Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety.
- Daily reporting of patient safety reports activity at Safety Huddle
- Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration
- Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports events
- Quality/Patient Safety/Risk oversight of patient safety reports event closure
- Routine patient safety reports report emailed to hospital leadership for review of reported events from past 24 hours
- Routine review of patient safety reports by Hospital Leadership and members of the Quality/Patient Safety/Risk team
  - Facilitation of early event identification for timely investigation/action as appropriate
  - Monitor for trends
  - Ensures routing of events to appropriate parties for review

Provider-related concerns and events escalated to

- service line leadership and/or peer review as appropriate
- Ensure that any mortality events are also captured in daily mortality report being reviewed by CMO/ACMO

- Intense Analysis/SEAs
  - o Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team
  - o Lessons learned and best practices shared via case studies at monthly Patient Safety Committee

Monitoring:

- Monthly report out via Quality Council
- Reporting through Board of Trustees (BOT)

Owner: Chief Medical Officer/ACMO

(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) COMPLETION DATE
A 309	Continued From page 113 13 and 2). The findings included: Review of the Quality Improvement Plan approved by the hospital Chief Executive Officer (CEO), Board of Trustees Chair and Chief Medical Officer (CMO) on 04/24/2023 revealed, " ...The hospital-wide Performance Improvement Plan is designed to improve quality performance and patient safety, ultimately reducing the risk to patients. ... ACCOUNTABILITY ... The following individual and/or committees are accountable for setting expectations, developing plans, and implementing procedures to assess, improve quality, and measure performance improvement within the organization. ... Board of Trustees ... The Board of Trustees delegates the responsibility for implementing this plan to the Medical Staff, through its Medical Staff committees and the hospital through its Quality, patient safety, and Performance Improvement Committees and leadership team. ..... The (hospital name) Quality Council was organized as an interdisciplinary team with representation of Department Directors/Managers, hospital leadership, and key staff members with input from the Chief Medical Officer. The functions of the committee include but are not limited to: ......2. Review data including continuous measurement activities of important functions. 3. Identify of (sic) problems/opportunities for improvement. 4. Review of actions planned or completed. 5. Evaluate of (sic) the effectiveness of actions completed. ...... Staff will be accountable to: 1. Detect adverse events and near-misses. 2. Report events or near-misses via the incident reporting system. 3. Comply with all policies and procedures to mitigate risk and loss to the facility.	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C **12/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 309	Continued From page 114 ... Aggregation and analysis of performance data is used to compare internal performance with industry standards, comparable organizations, and best practices. ......Data is collected in a systemic manner to: a Establish a performance baseline and compare to national benchmarks ... d) Identify areas of opportunity for more focused data abstraction/reviews ..... Data analysis is performed to identify processes to be targeted for change or improvement. The intent is to reduce the probability of adverse outcomes and eliminate patient harm events. The following events or outcomes require data analysis:...... b) Performance measurements that reveal significant undesirable variation from recognized standards..... h) Patterns of frequent event reporting (i.e. patient injury, including near misses)...... Patient Safety/ Risk Management is responsible for ensuring a culture of safety while promoting safe, error-free care, and a safe environment for our patients, staff and visitors. Patient Safety/ Risk Management works collaboratively with hospital personnel as they review and triage all reported events and create detailed analysis of the causes of events...... " Review of the hospital policy titled "Event and Close Call Reporting" revised 10/13/2022 revealed ". .. Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems ... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems. This policy applies to services provided by (Hospital Corporate Name) staff members in each of these settings:..... *Inpatient services, including acute care and behavioral health, critical access hospitals, and other related services * Emergency	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 309	Continued From page 115 Departments (ED) * Hospital-based outpatient department or ambulatory services, including but not limited to behavioral health services and Independent Diagnostic Testing Facilities ... *Physician practices or clinics that may include rural health clinics or federally qualified health care centers ... NC Division Clarification ... In addition to the roles listed in the policy, the Directors of Quality and Patient Safety and/or Administrative Quality Directors are also responsible for oversight of this process ... Escalation to Leadership ..." 1. Medical record review revealed Patient #58 had a witnessed fall on 04/26/2023 following abdominal surgery for a gun shot wound. A CT (cat scan) of the Abdomen and Liver on 04/26/2023 showed changes to a liver hematoma (clotted blood within the tissues) from the previous CT study on 04/25/2023. Patient #58 was moved to ICU (intensive care unit) for closer monitoring, and Interventional Radiology was consulted to rule out active bleeding. On 04/27/2023 Patient #58's hemoglobin dropped from 13.2 to 7.3 [6.0] and he received 2 units of red blood cells, and he underwent CT Angiogram and found no active bleed. Request for an event report on 12/05/2023 revealed there was not one available for Patient #58 after a witnessed fall, that required interventions. Telephone interview on 12/06/2023 at 1332 with RN #95 revealed she remembered the patient. Interview revealed "...he said he was going to pass out. We assisted him back to the bed after the fall and called a rapid response. I called the doctor. I didn't remember to complete a report, it	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 116 was not quite a fall. I guided him to the bed, and another nurse picked his legs up onto the bed..." Interview revealed Patient #58 had a witnessed fall, and an event report was not completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Interview on 12/06/2023 at 1409 with the Charge Nurse, RN #96 revealed "...if a patient falls, we complete a (named) an incident report..." Interview revealed for witnessed falls an incident report should be completed. Interview revealed an event report should have been completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Telephone interview on 12/07/2023 at 0906 with MD #94 revealed he remembered the patient. Interview revealed "...he had a traumatic liver injury it would not be surprising to have a rebleed, it required packing, and hemorrhage control. He did get an CT and have an interventional radiology angiography procedure after the event to ensure he didn't have an active bleed...It's impossible to tell...the fall did not extend an injury or stay at the hospital..." Interview revealed Patient #58 did have interventions after the fall on 04/26/2023 to ensure he had no active bleeding. Interview revealed hospital policy was not followed for event reporting for Patient #58 after a witnessed fall. 2. Review on 12/05/2023 of the policy Facility Event and Close Call Reporting Policy and Procedure, with effective date 04/01/2022 revealed "...PURPOSE: This policy is intended to minimize risks to patients, ...through the development and implementation of an event and close call reporting system based upon the	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 309	Continued From page 117	A 309		

affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report events and close calls to the Patient Safety Director, Risk Manager, or designee. Furthermore, this policy is intended to mitigate risks and improve quality of services by outlining the processes for factual reporting of events, close calls, and unsafe situations. POLICY: Facility staff will provide the needed data elements through a formal, documented event reporting system. Event reports should be completed as soon as possible after the event, but no later than the end of the shift...X. Fair and Accountable Reporting Culture...B. The responsibility for reporting an event or close call rests with any person who witnesses, discovers, or has direct knowledge of that event or close call..."

Medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported abdominal pain level of 10 of 10, and nausea and vomiting. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was not medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay in pain management, STAT lab work, STAT CT, and physician orders as prescribed.

Request for a Patient Safety Report (Event Report) revealed there was not one available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 118	A 309		

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed patients had delays in receiving pain management, STAT lab work and completion of physician orders in the ED waiting room. Interview revealed an event report was not completed for Patient #27.

Interview on 11/17/2023 at 1102 with NP #39 revealed she had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview revealed an incident report should have been completed for Patient #27.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to place orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not receive pain management, STAT lab work, STAT CT, and physician orders as prescribed. Interview revealed an incident report should have been completed for Patient #27.

3. Closed medical record review revealed on 3/4/2023, Patient #59 was admitted to the oncology unit and received a diagnosis of acute myeloid leukemia. Per physician orders, treatment for acute myeloid leukemia included Dacogen (intravenous chemotherapy medication) and Venetoclax (oral oncology medication). On 3/17/2023, the patient was infused Dacogen after two (2) [oncology nurses] verified the medication. Further review revealed on 3/18/2023, an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 119 Oncologist documented that the patient received an expired dose of Dacogen. The incident report for Patient #59's medication administration of the expired dose of Dacogen, was requested on 12/7/2023 at 11:00 AM from the Director of Quality. No incident report was provided. Upon inquiry for pharmacy unit inspections from March 2023 through November 2023 revealed there had only been one inspection documented on 5/16/2023. Interview on 12/6/2023 at approximately 8:45 AM with the oncology pharmacist revealed oncology patients could be located on any unit within the hospital, in which case, the oncology medication would be delivered from outpatient infusion pharmacy to the oncology unit. The oncology nurse(s) would be responsible for going to the perspective unit(s) for the administration (intravenous and/or oral) of the medication. The pharmacist was unaware that an oncology patient was administered an expired dose of Dacogen. Interview on 12/7/2023 at approximately 10:30 AM with oncology staff revealed that Patient #59 declined the first dose of Dacogen, which could have resulted in the administration of an expired medication. Interview on 12/7/2023 at 11:00 AM with the Director of Quality revealed the Oncologist failed to enter an incident report and/or failed to speak to anyone regarding the administration of an expired dose of Dacogen to Patient #59 that occurred 3/17/2023.	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 309	Continued From page 120 Interview on 12/7/2023 at 1:51 PM with the Oncology Unit Manager (OUM) revealed in April 2023 the oncology unit adopted a more detailed treatment administration checklist to assist the oncology nurses and the pharmacy department. The OUM further indicated she could not speak to the effectiveness of the updated checklist because no audits had been performed. Telephone interview on 12/8/2023 at 3:00 PM with the Oncologist revealed providers were made aware after-the-fact of any problems or concerns. As related to the administration of expired medication to a patient, the oncologist revealed, efficacy should be the main concern which falls upon the pharmacy department and was pretty sure this was what happened in the case of Patient #59. Further inquiry revealed that since the hospital joined [name of organization], the oncology unit lost valuable nurses which led to the hiring of new/inexperienced staff, and increased use of travel staff. The changes in staff led to an increase in errors, especially with neutropenic patients, which resulted in a degradation in care. Additionally, in the past oncology patients were directly admitted to the oncology unit without emergency department presentation. Now, oncology patients were admitted through the emergency department secondary to closure of transfers, which put the oncology patients at an increased risk for infection. Additionally, the unit no longer admitted complex cases of oncology patients because those cases were referred to other hospitals. Further interview revealed pharmacy errors increased secondary to the loss of experienced oncologist pharmacists. The interview concluded with the aforementioned concerns were voiced to the Medical Director for the oncology service line	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 309	Continued From page 121 in which there were no notifications or any observations of changes. 4. Review of the closed medical record for Patient #50 revealed a 21-year-old female presented to the Emergency Department (ED) via law enforcement under IVC (involuntary commitment) for a "Psychiatric screening exam; Behavioral health concern." Review of the Provider Note dated 05/04/2023 at 1640 revealed "... patient presents with IVC paperwork and recent behavior concerning for danger to others in particular ... I will have behavioral health services see the patient ..." Review of the Initial Psychiatric Evaluation dated 05/06/2023 at 0531 revealed "The patient is a 21 yo (year old) female with h/o (history of) autism and mild intellectual disability, who was brought to the ED under VC due to increasingly aggressive behavior. The IVC paperwork reports (sic) that the patient has been going around the neighborhood with a hammer. She has done thoughtless things such as covering her father's eyes with his hat while driving and then kicking him. THe (sic) patient's behavior has been escalating since she could no longer participate in her programs during COVID 19 (pandemic). Instead of going to a group home, she was d/c (discharged) home from her last program. She has been increasingly irritable since she is swinging to calm herself down and has demonstarted (sic) dangerous behaviors ... Nursing reports pt (patient) became unexpectedly agitated this AM (morning), pulled nurse and sitter's hair after being asked if her ears hurt (she was pulling at them). She received 5 mg (milligrams) Versed (medication to help you relax) at time of arrival to the ED yesteay (sic) afternoon, but otherwise no PRN (as needed) medication. She has not required restraint ... She is mostly mute (refraining from speech), although	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 309	Continued From page 122 sometimes echolalic (repeat others) and echopraxic (involuntary copying of another person's actions or movements). She waves when I wave. Says 'hello' when I say hello, and 'happy' when I ask if she is happy'(sic) ... Suggested plan; Uphold the IVC for now; observe the patient for the next 24-48 hours (sic); if the patient is stabilized, she can be discharged home or to a new placement, if one is available." Review of the Mental Health Contact Note dated 05/08/2023 at 1017 revealed "... reached out to Pt's mother, ..., and informed her that Pt was seen by Psychiatrist who is recommending discharge due to concerns of Pt safety on this unit, her aggressive behaviors w/ (with) other Pt's ..." Review of the Nurse Note dated 05/29/2023 at 0855 revealed "... This was the third time pt had attacked the hair of a sitter." Review of the Provider Note dated 05/29/2023 at 1007 revealed "...Patient was triggered by her sitter and attacked her this morning jumping on top of her and grabbing her hair ... Nursing staff reports this is the third sitter she is intact (sic) in the past 2 days ..." Review of the Nurse Note dated 06/10/2023 at 1920 revealed "Earlier today ... had multiple aggressive acts towards me, the first was when she spit on me as I was handing her a snack in the BHU (behavioral health unit) ... The second aggressive act came hours later when she saw me in the hall and came towards me. I attempted to walk away but she ran towards me, screaming and reaching for my face. She was able to pull the mask off my face but I restrained her hands and took several steps back, when she came after me again screaming and tearing at my head and face. I restrained her hands again and walked her back into her room towards her bed. As I let go and backed up ... leaned on her bed and kicked me in the chest with all her force ... I	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 309	Continued From page 123 don't intend to escalate this matter any further and have explained the entire situation to the psych clinician." Mental Health Contact Note dated 06/18/2023 at 2100 revealed "... sitting in BHU intake office and heard yelling. Pt seen ... on camera gripping a male pt hair in ... hallway bed. Pt was standing over male pt's hallbed (sic), hand in male pt's hair shaking pt's head around. Male pt was yelling ... immediately came out of BHU intake office, pt ran back towards her room into her bed. Male pt was visibly upset and yelling at pt in her room ..." Nurse Note dated 06/18/2023 at 2130 revealed "Pt. ran out of her room and pulled hair/hit another pt who was in a hall bed. After getting loose the pt. ran after her back in to her room, a BERT (behavioral health emergency) was called, physician, RNs, psych clinicians, and security all responded. The pt who was attacked aggressively was shouting, punching the walls, and hitting her bed. We were able to de-escalate the situation and both pts. We moved the second pt. to a differed pod in his own room so he would feel safe. It is unsure if (Patient #50) was hit while he was hitting her bed, physician did an assessment and she has no obvious injuries or marks. Pts are both settled in separate areas now." Review of the medical record revealed Patient #50 was discharged to a facility on 06/20/2023 at 1659. Review on 12/05/2023 of the incident/variance reports provided regarding Patient #50 revealed there were no incident/variance reports for the incident on 05/29/2023 nor on 06/10/2023 to correspond with the incidents described in the medical record notes. There were incidents dated 05/27/2023 and 06/18/2023. Telephone interview on 12/06/2023 at 1400 with	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 309	Continued From page 124 PSA #48 revealed she remembered Patient #50 and had to push her distress alarm button when caring for Patient #50. Interview revealed there had been several incidents involving Patient #50 pulling staff hair, attacking staff or other patients. Interview revealed PSA #18 had submitted incident/variance reports herself regarding more than one incident with Patient #50. Interview revealed there was a male patient in her room one time. PSA #18 could not remember the details about this incident, however confirmed she had filled out an incident report. PSA #18 stated there was a time when Patient #50 kissed another patient and an incident report should have been filled out about that. Interview on 12/06/2023 at 1500 with Director #82 revealed she only had four incidents/variances for Patient #50. Three of the four were dated 2022 and only one from 2023. Director #82 did not have the incident/variance provided to this surveyor dated 05/27/2023. Interview revealed the person entering the incident/variance did not enter the medical record number and Director #20 searched by the medical record number. Interview revealed it is hard to find incidents/variances if the medical record number is not entered so the information will pull across the system and make it easier to find. Interview revealed they can search by name however if the name is misspelled there would be problems finding any incidents/variances that were entered. Director #82 requested more time to research to see if there were more incidents/variances. At time of exit from facility on 12/09/2023 at 1600, Director #82 had not provided any additional information to this surveyor regarding additional incidents/variances for Patient #50.	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 125 5. Closed medical record review of Patient #15 revealed a 21 year old male admitted on 08/14/2023 with abdominal pain. Record review revealed the patient had laparoscopic converted to open total abdominal colectomy (remove all or part of colon) with end ileostomy (stoma-opening in abdomen surgically created) on 08/27/2023 for ulcerative colitis. Record review revealed on 08/27/2023 at 1117 a ketamine drip was ordered stat (urgent). Record review revealed the patient arrived in PACU (post anesthesia care unit) at 1120. Patient transferred to floor (unit) at 1420. Record review revealed ketamine was started at 1448 on the unit. Patient returned to PACU at 1515 for ketamine drip. Review of nursing note on 08/27/2023 at 1526 revealed "Ketamine gtt (drip) sent to floor from pharmacy rather than to PACU. Patient arrived on the unit from PACU without ketamine gtt started. Notified (named) CNC (clinical nurse coordinator) and called to PACU nurse for patient to be transferred back to PACU for ketamine gtt initiation and required monitoring." Review of nursing note on 08/27/2023 at 1656 revealed "Pt (patient) transferred to floor after report called to RN (registered nurse). PT was ordered Ketamine and the pharmacy sent the medication to the nursing unit instead of PACU. RN agreed in report to start ketamine on pt arrival to floor, since the ketamine was on the unit. Pt later brought back to pacu when nurse became aware that she was not cleared by hospital regulations to start the ketamine gtt." Review of a ketamine drip timeline document revealed Ketamine drip ordered at 1117. The order was verified by pharmacy at 1140, but the label was not printed. Missing medication request sent by the RN at 1228, high priority with	A 309		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 309	Continued From page 126	A 309		

comment "please bring to PACU pod 2 bay 9". Medication request was accepted by pharmacy at 1243 and label was printed. Label stated A3W/A336 as location. Medication hand delivered to staff and signed as received by the named RN. Ketamine drip documented as initiated at 1448. Review of ketamine delivery signature sheet revealed no time of acceptance documented.

Review of the incident/variance reports provided regarding Patient #15 revealed there were no incident/variance reports for the incident on 08/27/2023 to correspond with the incident described in the medical record notes.

Interview on 11/16/2023 at 1045 with RPH #87 revealed medications are sent to locations based on the patient's location in the medical record. Interview revealed when patients are in PACU the pharmacy staff rely on nursing to put in a missing medication request in order to get the drug to the correct location.

Interview on 11/16/2023 at 1230 with PA #90 who ordered the drip revealed the drip was supposed to be initiated as soon as possible. Interview revealed the ketamine drip should have been started before the patient went to the floor. Interview revealed "the periop phase can be tricky and the patient's location does not populate automatically."

Interview on 11/16/2023 at 1421 with RN #88 revealed the PACU staff had waited for hours for the pharmacy to fill the order. Interview revealed the medication had been delivered to the floor and not to PACU. Interview revealed pharmacy was called several times to inquire about medication, "So we thought they knew that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 127	A 309		

patient was in PACU since we kept calling."

Interview on 11/17/2023 with Nurse Manager (NM) #89 revealed ketamine drips are not done on the unit, they should be initiated on a higher level of care unit. Interview revealed the unit and pharmacy staff received education on which units can not initiate the ketamine drip. Interview revealed the education was in 12/2022. Interview revealed more education would be given to staff.

Interview on 11/27/2023 at 1540 with RPH #79 revealed the nursing staff would put in a medication request when they are ready for the medication to be prepared. The RN has to put in the location of the patient with the medication request. Interview revealed the pharmacy staff that processed the label may not be the same staff member that delivered the order, and the patient's location may not have been communicated to the delivery technician. Interview revealed the delivery technician would then go by the location that was printed on the label.

Request to interview a floor nurse revealed not available for interview.

Request to interview the unit CNC revealed not available for interview.

6. Review of a policy titled "Physiologic Monitoring-Cardiac Telemetry Monitoring..." with a revision date of 08/14/2023, revealed "Internal (lateral) transfers within the (named hospital). C. Patients transferring to non-ICU (Intensive care unit) units with continuous ECG (Electrocardiogram) orders will transport on

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 128 continuous ECG. 2. The receiving RN will notify CMU (cardiac monitoring unit) with patient name/MRN (medical record number), room being transferred to and telemetry box being assigned." Closed medical review on of Patient #13 revealed a 76 year old male admitted on 08/19/2023 at 1430 for hypertension (high blood pressure) and Intracranial hemorrhage (brain bleed). Review of RN #53's note written on 08/25/2023 at 1750 revealed "Transferred to Floor. Transfer Report Given to (RN #54). Transport equipment: Monitor. Mode: Wheelchair." On 08/25/2023 at 1934, Patient #13 was transferred to a stepdown unit. Review on 11/15/2023 of an incident report written by CMU supervisor #52 revealed (Patient #13)" had active 48 hr (hour) tele (telemetry) orders from 08.24.2023 at 1348 but were (sic) not being monitored." Review of telemetry strips failed to reveal a telemetry strip for evening hours of 08/25/2023. Review revealed Patient #13 was not monitored by telemetry for 6 hours. Review of a Safety Event Timeline dated 08/29/2023 at 1408 from Manager #56 from Floor A revealed "Status: Assigned to Manager #55, Manager of Floor B (sending floor manager)." Review revealed on "08/31/2023 at 1234, Status: Assigned. Closed." Review revealed no further documentation from Manager #55. Review revealed no documentation of the investigation of the Patient #13 without telemetry monitoring. Interview on 11/15/2023 at 1605 with CMU supervisor #52 revealed a daily audit is conducted at 0100 and 1300 of telemetry patients to ensure patients are being monitored as ordered. Interview revealed Patient #13 was found to have an order for telemetry but was not	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 129	A 309		

being monitored. Patient #13 had not been monitored since transfer to another floor on 08/25/2023 at 1934. Interview revealed Patient #13 was placed on telemetry on 08/26/2023 at 0139, 6 hours and 5 minutes after transfer to the floor.

Interview on 11/28/2023 at 1234 of RN #54 revealed no recollection of Patient #13 or details of the transfer. Interview revealed RN #54 had not been interviewed regarding the incident of Patient #13.

Interview on 11/28/2023 at 1633 of RN #53 revealed no recollection of Patient #13 or details of the transfer.

Interview on 11/30/2023 at 1645 with Risk Manager #58 revealed "incidents should be reviewed and escalated to the department leaders. There should be notes from the manager."

Interview of Manager #55 was not obtained due to no longer employed.

In summary, Patient #13 was transferred to Floor B with telemetry orders. After 6 hours, Patient #13 was discovered without telemetry. There was no review of the incident from the management of the sending floor or risk management.

7. Medical record review on 11/14/2023 of Patient #2 revealed the patient arrived to the Emergency Department (ED) on 10/17/2023. Review of the EMS Patient Care Record revealed EMS received a call at 1654, arrived to Patient #2's home at 1720 and transported the patient to the hospital, arriving at 1748. EMS documented

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 309	Continued From page 130	A 309		

they transferred care of the patient to the hospital at 1907, 1 hour 19 minutes later. Prior to the transfer of care, review revealed EMS continued monitoring Patient #2. A note in the EMS record indicated "Turn Around Delays.....ED Overcrowding/ Transfer of Care......."

The hospital emergency department record review revealed the patient arrived at 1753 via EMS, with complaints of chest pain, shortness of breath, and syncope. Patient #2 was noted as evaluated by a provider at 1845 (52 minutes after arrival) and triaged by a RN at 1900 (1 hour, 7 minutes after arrival). An EKG was completed at 1905 (1 hour 12 minutes after arrival) and labs, including troponin, were drawn at 1920 (1 hour 27 minutes after arrival). Record review revealed a delay in the hospital accepting the patient from EMS, triaging and initiating care to the patient, including an EKG and labs. Patient #2 went into cardiac arrest at 1953 (2 hours after arrival) and subsequently expired after failed resuscitation attempts.

Review of a document received from the hospital related to this patient, on 11/16/2023, revealed it was not dated or timed and was not signed. Document review revealed the following statement: "I have reviewed this case and the initial presentation, the timing on the workup, the findings and escalation were all appropriate and met standard of care. The patient arrived at 1753, was roomed at 1830 and was seen by a clinician at 1845 the patient coded at 19:53 and had a time of death at 22024 (sic) all of which occurred while in a room. The EKG was reviewed by the initial clinician and reported in the chart. The patient coded at 1953 and Dr. (Name) was called to the Code. During the code Dr. (Name) has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 309	Continued From page 131	A 309		

documented that the patient had brief return of consciousness with the ongoing CPR. During this time he began reviewing the workup and the EKG, which was handed to him at 2002. It was read as sinus rhythm with a PVC and a 4 beat run of non-sustained ventricular tachycardia. He signed this EKG at this time 2002, the code was continued for another 22 minutes before time of death." There were no other notations on the received document including no identification of who completed it or when. The document did not identify any areas of concern. There was no documented review of the timing of triage or implementation of orders. Additional information on the document was requested on 11/17/2023. No updated information was received.

Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed EMS was able to give hand-off report to a nurse at 1907 (over an hour after arrival). Interview revealed wait times for EMS to hand-off patients had recently gotten more common.

Telephone interview with RN #66, on 11/16/2023 at 0938, revealed that until patients were in a room and care handed-off from EMS, they were "counting on EMS to care for (the patients). ...."

Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the goal for screening evaluations was 20 minutes from arrival.

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. MD #72 acknowledged a delay with Patient #2. Interview revealed the physician was not aware if there was

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A 309	Continued From page 132 a review of the case. Review of documents received did not reveal an incident report. Review of findings and document provided revealed the hospital failed to identify and evaluate delays in accepting, triaging and initiating care and treatment for a patient presenting via EMS with chest pain.	A 309		
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 policy review, medical record review, incident report review, EMS trip report review, and staff and provider interviews, the hospital's nursing staff failed to have an effective nursing service providing oversight of day to day operations by failing to ensure systems were in place to supervise and provide safe delivery of care to patients presenting to the emergency department (ED). The findings included: 1. The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the emergency department for 4 of 35 sampled ED records reviewed (Patient #'s 28, 43, 27, and 2). Cross refer to 482.23 Nursing Standard: Tag A 0392.	A 385	**Subject of Deficiency – A 385** The hospital's nursing staff failed to have an effective nursing service providing oversight of day to day operations by failing to ensure systems were in place to supervise and provide safe delivery of care to patients presenting to the emergency department (ED). Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below. **Immediate Corrections and System Changes** **Immediate Actions Taken:** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings: 12/1/23-Added further financial incentives for trained and competent staff to pick up in the ED above their current commitment. These departments included: phlebotomy, MedCom, Monitor Techs, Transport, EVS, Guest services, and Registration (Patient Access Services) staff. 12/2/23 -Leadership meeting to determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing	12/1/23 12/2/23

Officer's, and Vice President of Emergency Services.
Actions taken specific to staffing from that meeting:

- Developed and implemented a schedule for expanded ED leadership coverage to include weekends and nights
- Requested a performance improvement review of ED staffing and efficiencies
- Outlined and educated ED staff (RN, CNC, Paramedic, PCT's, HUC, and ED Leadership) around triage escalation process and deployment of additional triage team members when necessary. Education provided by CNC, Educators, and ED Leadership.
- Added ED Interim leaders.

12/4/23 Deployment of Emergency Department Performance Improvement team to evaluate staffing, processes, and provide recommendations. — 12/4/23

12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).

12/8/23 Added further financial incentives for as needed staff and travelers to pick up additional shifts above their current commitment. — 12/8/23

12/9/23 On site survey ended with DHHS with disclosure of two additional concerns under the same conditions of participation (Emergency Services, Patient Rights, and Nursing Services). — 12/9/23

12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses. — 12/12/23

12/16/23 Incident Command Structure established with Daily Emergency Operations Coordination Call (DEOCC) with hospital and additional leadership to review the following: Hospital and ED volumes, review of ED and inpatient metrics related to throughput, Inpatient and ED staffing, support staffing, HR and recruitment updates, and staffing requests. The goal of this call was to quickly obtain approval to mitigate barriers, as well as to have continuous oversight at all levels of the organization. — 12/16/23

Plan of Correction	Completion Date
12/17/23 Emergency Operations Team on site to provide continuous support of Emergency Operations.	12/17/23
12/18/23 Three inpatient leaders were redeployed to assist with oversight in the emergency department.	12/18/23
12/19/23 Exit conference with DHHS team and letter receipt which included the following information: that the state was recommending 23-day termination due to noncompliance with the COP's of Emergency Services, Patient Rights, Nursing Services, as well as, Governing Body, Laboratory Services, and Quality Assurance. We were informed that CMS office in Atlanta would make the final determination regarding compliance or non-compliance with the COP's. No additional detail was provided at that time.	12/19/23
12/21-12/29 ED and Inpatient staffing rapid response nurses deployed to Mission Hospital. A rapid response nurse is, a nurse who is able to arrive within approximately ten days of notice. They are competent in their area of specialty and complete traveler orientation on arrival to the facility. These resources were in addition to the travelers already in place throughout the facility. The primary focus of this deployment was to open up inpatient capacity, assist in the ED with shift coverage, and supplement current staffing until additional permanent staff could be hired and onboarded.	
12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses.	12/29/23
1/2/24 Increased overall ED traveler RN's based upon a continual assessment of ED staffing and onboarding.	

Ongoing Actions and System Changes

1/11/2024 Comprehensive review of ED assignments/shifts resulted in modifications to better accommodate patient arrival patterns via EMS and walk-in.

1/1/2024-2/1/24 The following resources/actions were taken to continue to address staffing in the Emergency Department:

- Additional interim leadership was added.
- Added dedicated ED transporter at peak times.
- Added ED Central Monitoring Unit

(CMU) resource at peak times.

- Departments that had incremental additions (i.e. travelers) to support the ED were: MAMA Ground Ambulance Transport, in-house transport, Environmental Services, Case Management, Phlebotomy, Respiratory Therapy, Physical Therapy, and the Central Monitoring Unit.
- Evaluated and modified front-end triage process to better align resources with patient arrival patterns.
- Modified closure review tool to increase sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department.
- Real time staffing is reviewed by the Charge RN, Administrative Supervisors, Nursing Leadership, and Staffing Coordinators to support patient acuity changes and/or adjust patient volumes.
- There is a rounding Administrative Supervisor who works directly with the staffing coordinators on a 24/7 basis to support staffing decisions to align with both census and overall patient care needs.
- The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.
- Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be provided, and the caregiver competency and scope of nursing practice.
- Mission hospital is continuously recruiting and making efforts to retain current employees. Year to date (2024) Mission hospital ED has hired 17 RN positions, 2 CNC positions, and 4 StaRN (New Nurse) positions.

2/1/2024 Transmittal of 2567 received from CMS to Mission Hospital CEO — 2/1/24

Monitoring for Compliance:

If the number of staff available does not meet the needs of the ED due to surge, call-outs, etc., in a given shift the hospital evaluates staffing utilizing the following processes:

- The patients on each unit are evaluated based on their acuity and level of care and assignments are adjusted as appropriate.
- Charge nurses are utilized to deliver direct patient care
- Staff who are not working are asked to pick up through various communications in advance as well as throughout the shift as appropriate
- Staffing is reevaluated at a minimum of every 4 hours to determine if resources can be shifted as appropriate
- Unit capacity is determined by Nurse staffing office in conjunction with Administrator-On-Call (AOC)
- Hospital closure to incoming transfers and out of county EMS volume is determined at a minimum of 4 times a day by AOC
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP of Emergency Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 385	Continued From page 133 1. The hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for 11 of 35 ED records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). Cross refer to 482.23 Nursing Standard: Tag A 0398. 2. The hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered and evaluate and monitor the effects of the medication for six (6) of 35 patients presenting to the emergency department (Patient #'s 92, 83, 43, 28, 27, and 26). Cross refer to 482.23 Nursing Standard: Tag A 0405.	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 policy, medical record review, incident	A 392	**Subject of Deficiency – A 392** The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the Emergency Department (ED) Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below. **Immediate Corrections and System Changes:** **Immediate Actions Taken:** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings 12/2/23 -Leadership Meeting to Determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief	12/2/23

Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing Officer's, and Vice President of Emergency Services. Applicable actions taken from that meeting include:

- Developed and implemented education as outlined below
- Implemented a timestamp process to accurately capture the arrival time of patients at triage
- Development of audit tool to track timely care delivery through arrival to triage, order to lab collect, pain medication assessment/reassessment, order to intervention
- Developed and implemented timely and frequent real time communication structure involving ED CNC/ED leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
- Developed and implemented a schedule for ED leadership coverage to include weekends and nights
- Requested and received additional incentives for ED staff, support staff, and inpatient staff to pick up extra shifts.

12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).

12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses. 12/12/23

Additional immediate and ongoing actions:

- Designated inpatient nursing to care for inpatient holds and provide care within their designated scope/competency in the emergency department as needed. Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be

provided, and the caregiver competency and scope of nursing practice.

- Requested additional inpatient and emergency department rapid travel nursing staff.

System Changes:

- Evaluated front-end triage process to better align resources with patient arrival patterns. Assembled a team to include (pharmacy, radiology, lab, patient access, care experience, emergency department nurses, providers, IT, nursing administration, emergency department leadership),
    - Staffing Adjustments: Added a second triage nurse during peak times, second charge nurse for waiting room/ internal processing area, assembled two intake teams to assist with patient care implementation and waiting room throughput. Staffing assignment sheets adjusted to reflect the new changes.
    - Converted front end rooms to optimize new front-end process
    - Implemented quick registration and rapid triage process
    - Educated staff (RNs, CNCs, Paramedics, PCTs, HUCs, and ED Leadership) on new front-end process, medication verification (as required by specific scope), tracking and trending outcomes with data
    - Educated providers as outlined above as applicable per scope
    - Worked with pharmacy to standardize medication storage units
    - Worked with laboratory services on available equipment and identified additional resources needed
    - Data reviewed every two hours with issue and action closed loop communication, daily action plan for task and assignment review
    - Increased leadership coverage

to include weekends and nights to maintain oversight of emergency department operations
    - Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput.
- Modified closure review tool to increase sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department.
- Real time staffing is reviewed at AM and PM staffing assignments by the Charge RN, Administrative Supervisors, Staffing Coordinators, Performance Improvement Team, and Nursing Leadership to support patient acuity changes and/or adjust patient assignments as appropriate.
- The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.

Monitoring for Compliance/Audit Details:

Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- Arrival to Triage Times for walk-in and EMS
- Arrival to EKG order-to-complete per policy/protocol
- Pain Medication assessment/ reassessment per policy/protocol
- CIWA assessments per policy/protocol
- Realtime escalation of patient safety concerns
- CT order to exam

Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to-completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant EKG order-to-completion per policy/protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.

- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits
  Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits
  Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP Emergency Services

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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) COMPLETION DATE
A 392	Continued From page 134 report review, and staff and provider interviews, the hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the Emergency Department (ED) for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). The findings included: Cross refer to §482.55 Emergency Services Standard: Tag 1101. The ED nursing staff failed to ensure emergency care and services were provided according to policy and provider orders. Patients were not accepted upon arrival to the ED, evaluated, monitored and provided treatment to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26. 1. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of	A 392		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 392	Continued From page 135	A 392		

continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented.

2. Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.

3. Patient #43, a 39-year-old who presented to

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A 392	Continued From page 136	A 392		

the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury.

4. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV

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A 392		A 392		

Continued From page 137
were not monitored and the bag ran dry with subsequent cardiac arrest.

5. Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing).

7. Patient #6 arrived to Hospital B with strokelike

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A 392	Continued From page 138	A 392		

symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff.

8. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED.

9. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated

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A 392	Continued From page 139 D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment. 10. Patient #26 presented to the ED via EMS on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022. 11. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. Record review revealed the patient did not have her vital signs monitored and had no nurse assigned to monitor status or provide care.	A 392		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism	A 398	**Subject of Deficiency: A 398** Hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders	

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A 398	Continued From page 140 through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on policy review, medical record review, incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for eleven (11) of 35 patients records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). The findings included: Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS: ... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or	A 398	**Plan of Correction:** Summary of policies/guidelines and any other documents reviewed or revised during POC development: • Assessment/Reassessment, 1PC.ADM.0013 • Pain Assessment and Management, 1PC.ADM.0002 • Physiologic Monitoring – Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring, Non-Invasive Blood Pressure Monitoring (NIBP), 1PC.NRS.0001 • Triage – Emergency Department, 1PC.ED.0401 • Triage Treatment Guidelines – TTGs, 1PC.ED.0402 • CIWA Withdrawal Plan 2/22 **Immediate Corrections and System Changes:** **Immediate Actions Taken:** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings 12/2/23 -Leadership Meeting to Determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing Officer's, and Vice President of Emergency Services. Applicable actions taken from that meeting include: • Developed and implemented education as outlined below • Implemented a timestamp process to accurately capture the arrival time of patients at triage • Development of audit tool to track	12/2/23

timely care delivery through arrival to triage, order to lab collect, pain medication assessment/reassessment, order to intervention

- Developed and implemented timely and frequent real time communication structure involving ED CNC/ED leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
- Developed and implemented a schedule for ED leadership coverage to include weekends and nights
- Requested and received additional incentives for ED staff, support staff, and inpatient staff to pick up extra shifts.

12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).

12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses

12/12/23

Additional immediate and ongoing actions:

- Designated inpatient nursing to care for inpatient holds and provide care within their designated scope/competency in the emergency department as needed. Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be provided, and the caregiver competency and scope of nursing practice.
- Requested additional inpatient and emergency department rapid travel nursing staff.

System Changes:

- Evaluated front-end triage process to better align resources with patient

arrival patterns. Assembled a team to include (pharmacy, radiology, lab, patient access, care experience, emergency department nurses, providers, IT, nursing administration, emergency department leadership),

- Staffing Adjustments: Added a second triage nurse during peak times, second charge nurse for waiting room/ internal processing area, assembled two intake teams to assist with patient care implementation and waiting room throughput. Staffing assignment sheets adjusted to reflect the new changes.
- Converted front end rooms to optimize new front-end process
- Implemented quick registration and rapid triage process
- Educated staff (RNs, CNCs, Paramedics, PCTs, HUCs, and ED Leadership) on new front-end process, medication verification (as required by specific scope), tracking and trending outcomes with data
- Educated providers as outlined above as applicable per scope
- Worked with pharmacy to standardize medication storage units
- Worked with laboratory services on available equipment and identified additional resources needed
- Data reviewed every two hours with issue and action closed loop communication, daily action plan for task and assignment review
- Increased leadership coverage to include weekends and nights to maintain oversight of emergency department operations
- Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput.

- Modified closure review tool to increase

sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department.

- Real time staffing is reviewed at AM and PM staffing assignments by the Charge RN, Administrative Supervisors, Staffing Coordinators, Performance Improvement Team, and Nursing Leadership to support patient acuity changes and/or adjust patient assignments as appropriate.
- The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.

Education:
Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. **Education has been incorporated into new hire and contract staff education**. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals — 12/2/23
- 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight — 12/2/23
- 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals — 12/2/23
- 12/2/2023 ED nursing staff educated regarding EKG completion timely per — 12/2/23

policy/protocol

- 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment — 12/14/23
- 12/21/2023 ED nursing staff education regarding telemetry order initiation — 12/21/23
- 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process — 12/21/23
- 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff — 12/21/23
- 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway — 12/21/23
- 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversations with nursing staff completed by education team — 1/15/24
- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front-end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24
- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation — 2/6/24

Monitoring for Compliance/Audit Details:

Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- o Arrival to Triage Times for walk-in and EMS
- o Arrival to EKG order-to-complete per policy/protocol
- o Pain Medication assessment/ reassessment per policy/protocol
- o CIWA assessments per policy/protocol
- o Realtime escalation of patient

safety concerns
- o CT order to exam

Sustained Compliance Audits to Ensure POC is Effective:
Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to-completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant EKG order-to-completion per policy/protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits
  Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits
  Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP Emergency Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 141 caregiver. 2. A comprehensive assessment, performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale, allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 142 patient will need to wait in the lobby. While in the lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines….." Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. .... The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated and immediate life-threatening needs are determined with appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial,	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 143 physiological, and age-specific needs of the individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...." 1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A 398	Continued From page 144 labs including CBC, chemistry, lipase and troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 145 needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization. ..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 146 of STEMI (ST elevation myocardial infarction), Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR. Interview on 12/09/2023 at 1210 with Assistant Director of Nursing (ADON) #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor. In summary, Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate. Findings of an EKG at 2110 showed ST elevation, **ACUTE MI/STEMI**. A STEMI Code Activation was initiated for an evolving lateral STEMI. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. 2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 147	A 398		

revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. "

Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 148 11/28/2023 at 1216 with a chief complaint of dizziness from her doctor's office. Patient #83 was seen by an ED Medical Doctor (MD) #1 on arrival and at 1218 a comprehensive metabolic panel (CMP) [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 Registered Nurse (RN) #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 149 inpatient bed. At 2329 Hospitalist MD #9 ordered an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). On 11/29/2023 at 0127 MD #9 ordered a Lactic Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these , later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 canceled the 0127 NOW Lactic Acid order "nurse collect" from the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 150 after ordered) with result of 12.3 (normal high range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was in the lab for processing at 0907, and resulted at 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337. Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 151	A 398		

(within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work.

MD #9 was unavailable for interview.

MD #16 was unavailable for interview.

Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed.

Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble getting in contact with the phlebotomist. That morning they were not logged into to their imobile device. I called the general lab number, and no one answered. I then contacted my house

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 152	A 398		

supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on 12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I strongly advocated for her to get moved into a bed with the CNC (clinical nurse coordinator), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 153	A 398		

it didn't happen. She didn't think it was a big deal. We don't have the capability to link the patient to a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83.

Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, RN #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83.

Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 154 Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was canceled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol Withdrawal Plan, effective date 07/20/2022 revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less than) 15..." The CIWA/Alcohol Withdrawal Plan	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 155 Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10. Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..." Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure 141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, EKG, and chest X-ray were completed, and Patient #43 was assigned to ED Medical Doctor (MD) #23. Review of the ER Physician Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, EKG and chest X-ray results from 08/14/2023 did not show any	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 156 critical results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4 mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1 mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1 mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and a CIWA Scale reassessment was due to be completed per protocol. No nursing reassessments, medication administrations, IV access/fluids, or physician orders were completed	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 157 after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4 mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was documented before the patient had a seizure event with sustained head injury. There was no nursing reassessment, or nursing care after 08/14/2023 at 1851 by RN #22 until 08/15/2023 at	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 158	A 398		

0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at 0334 from the ED. Patient #43 was discharged home on 08/17/2023.

Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to sent out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload."

MD #23 declined to be interviewed.

Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be monitored ..." Interview revealed MD #26 had concerns for patient safety in the ED waiting room due to delays in patient monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 159	A 398		

Interview on 11/15/2023 at 1615 with Nurse Practioner (NP) #36 revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 160	A 398		

doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43.

Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43.

Interview on 12/08/2023 at 1230 with Nursing Vice President of ED Services (VPED) #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not been completed.

Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 161 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency severity index (ESI) of 1-Resuscitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG, lab work, chest X-ray and CT (cat scan) of the head. At 1005 Haldol (given to treat severe	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 162 behavior) 10 mg Intravenous was ordered by MD #59 and given due to combativeness. Review of the ER Note by MD #59 dated 07/05/2023 at 1002 revealed ".....history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now,... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm 3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed .. The Head CT was negative. Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes. We have been running	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 163 norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4 mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20 mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 164 it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040. Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assignment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 165 and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 166 Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 167 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation. ED RN #68 was not available for interview. ED RPH #78 was unavailable for interview. ED Manager RN #75 was unavailable for interview. ED Director, RN #76 was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 168 explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available). Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull resources..." Further interview with CNC RN #74 revealed "...she had no concerns with nursing reassessments in the ED... that nursing assignments in the Red Pod (where the most	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 398	Continued From page 169	A 398		

acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care.

Interview on 11/15/2023 at 1637 VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed.

Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 170	A 398		

#77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him.

Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did.

Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PA's assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 171 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 172 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5 mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136. Request for a Patient Safety Report (Incident Report) revealed there was not one available. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any labs or orders completed. At	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 173	A 398		

that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022.

Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.

Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 174 pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management. 6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters (ml). Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER (emergency room) Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain medication, antibiotics, and lab work." PA #45 ordered X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients) Hallway Bed 7. At 1517 Patient #29 was triaged	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
A 398	Continued From page 175 by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2 (oxygen) 20g (gauge) Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), Registered Nurse, (RN) #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4 mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5 mg IV for a pain score of 10/10 and Zofran 4 mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain reassessment was charted as 9/10 (no evidence of an oxygen reassessment). At 1748 the Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 176	A 398		

tibial shaft fracture..." with plan for surgery to repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5 mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (do not resuscitate) [no evidence of this in the record]. She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at 1909.

Review of the Patient Event Record dated 04/06/2022 at 0341 by Nursing/Surgical Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 177 #54 revealed the event was "unexpected death" date of event "04/05/2022 at 1903" with narrative "...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsive in hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to event per report. Trauma Nurse, RN #56 was unavailable for interview. Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital policy for reassessment was not followed for Patient #29. Telephone interview on 11/16/2023 at 1324 with	A 398		

A 398 Continued From page 178 A 398

MD #46 revealed she did not recall Patient #29. Interview revealed "...monitoring of patients in hallway beds are a concern. Ideally every patient in the Red Pod should be on some sort of a monitor with a pulse oximeter (oxygen monitor). More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside.

Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29.

Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be placed on a cardiac monitor which showed asystole. At 1909 was the time of death pronounced with her daughter at the bedside. Interview revealed this event was reviewed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 179	A 398		

Mortality and Morbidity which was comprised of multiple providers and the MD who had completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.)

Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and again at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing).

7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood thinners and 10 days post partum. What aspect of reason for visit is concerning to patient? :

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 180 Stroke symptoms. ...... " Review of a MD "ER Report", service date/time 10/03/2023 at 1714, revealed " .... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the fact the patient is 10 days postpartum which does place her at an elevated risk for ischemic CVA	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 181 (stroke). Differential at this point would also include complex migraine, preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke...... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most urgent transport)......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no obvious distress....report is as follows: .....Dx (Diagnosis): HTN (hypertension) crisis,	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 398	Continued From page 182 Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and weakness and tingling onset....10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and leg weakness along with a facial droop and neck pain. Vital signs continued approximately every 5	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 398	Continued From page 183 minutes, with the last recorded blood pressure 147/90 at 2215. Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H.....ED Full Triage Arrival Mode - ED (Emergent) : EMS.....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital....." Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form.... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry neurologist decision was made against using tPA (breaks down blood clots). She was transferred here for further stroke eval and MRI (magnetic resonance imaging). She was also notably	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 184 hypertensive at outside hospital with blood pressure 160s systolic. She has also had some headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here. Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop Preeclampsia...... " Record review failed to reveal acceptance and monitoring of Patient #6 by	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 185 nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023. Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring. Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 186 patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible." Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia. Telephone interview with Patient #6's Triage Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation. Interview revealed the EMS team was responsible for any patient they brought in until	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 187 the patient got a room assignment and was moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Telephone interview on 11/17/2023 at 1205 with MD #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics. In summary, Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 188 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed " ...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed ".... History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)...... Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with neurologic symptoms concerning for acute ischemic stroke I think she will likely be a candidate for thrombolytics assuming that we can get her blood pressure down. She is going to CAT	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 189 (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. ...." Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority. Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). ..... THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED ....THE PHYSICIAN ADVISED TARGET BLOOD PRESSURE IS 140/90 AND ADVISED TO	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 190 MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE..... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT.... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED......" Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and hand-off to the hospital. Review of the Hospital A medical record for Patient #1, on 11/14/2023, revealed the patient	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 191 arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351, revealed " ... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management ....Physical Exam ....Initial Vitals No Data Available ... Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making ..... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ...." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated " ...Impression and Plan:...... #ICH (Intracranial Hemorrhage): hypertensive etiology suspected .... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on one side of the body). Plan: admit to ICU for close neurologic monitoring. ..." Review of the ED record failed to reveal any vital signs or assessments by nursing. Review revealed "Nurse	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 192 Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by (Name), RN. ED CNC (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85. Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED. Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients in the ED as soon as they were notified of the patient's arrival. Interview revealed it was	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398		A 398		

Continued From page 193

"surprising" not to have vital signs completed in the ED and stated it did not meet expectations for care - patients needed hourly neuro checks and vital signs with provider updates on changes.

Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN.

Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 194 unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE BIG TOE OF HIS LEFT FOOT. IT WAS NOW NOTED THAT PT'S EKG WAS SHOWING	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 195	A 398		

....ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY A&Ox4 PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN......" EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care......"

Review of the medical record, on 11/14/2023,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 196 revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7. Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed " ... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks .....He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic , Diflucan (antifungal), and Duricef (antibiotic). ....Medical Decision Making...... EMS reports that they gave patient 324 mg aspirin...... blood pressure was approximately 96 mmHg. They gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that patient had 7 beat run of V tach on their EKG tracing in route with patient now in sinus rhythm	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 197	A 398		

and occasional bigeminy. Ordered EKG and for patient to be on telemetry .....Point-of-care CBG (blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach ... 1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017 .... Called lab to request results of chemistries be available as soon as possible. Labs resulted after arrest .... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack).

Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 398	Continued From page 198 ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm .....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For this patient who presented with chest pain, syncope, and suffered cardiac arrest has either	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 398	Continued From page 199 suffered an MI or rhythm disturbance...... I reviewed his medications..... I made attempts to address .....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole .....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46 ... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest. ..." Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17 minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently and it seemed like a staffing issue.	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 398	Continued From page 200	A 398		

Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the patient came into the ED with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival.

Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient #2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in a room and care handed-off from EMS, interview

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 398	Continued From page 201 revealed, they were "counting on EMS to care for (the patients)......" Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment. 10. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 202 ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival). Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be seen by providers and prescribed medications	A 398		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 203 while "on the wall" but can not get them because no RN has been assigned. 11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention". Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment..." Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 398	Continued From page 204 applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	A 398		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.	A 405	**Subject of Deficiency: A 405** Hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered, and evaluate and monitor the effects of the medication Each individual Condition of Participation plan of correction for the cross-referenced tag in this section are outlined below.	

Plan of Correction:

Immediate Actions Taken
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:

- Medication Administration Assessment/Re-assessment Completed as indicated
  - 12/2/2023 Staff education with attestation (12/2/23)
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool.

Education:
Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. **Education has been incorporated into new hire and contract staff education**. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- ED nursing staff remedial education with attestation post-opiate medication administration assessment
- ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles.

Action:

- Timely and frequent communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
- ED tracking board enhancements to include vital sign, telemetry, pain reassessment, and EKG icons
- EHR enhancement of visual cue to prompt staff to better capture post-medication administration assessments

Monitoring for Compliance/Audit Details:
The monitoring and tracking procedures that will be implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Routine monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Routine monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 405		A 405		

Continued From page 205

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.
This STANDARD is not met as evidenced by:
Based on policy review, medical record review, incident report review, EMS trip report review, and staff and provider interviews, hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered, and evaluate and monitor the effects of the medication for 6 of 35 patients presenting to the emergency department (#92, #83, #43, #28, #27, and #26).

The findings included:

Cross refer to A-0398 for all examples.

Review of a "Pain Assessment and Management" policy revised 01/05/2022 revealed, " ... Each patient is screened for the presence of pain in all settings where treatment is provided. ......3. For emergency departments (ED), patients will be screened for pain during each ED visit. ...... The frequency of pain assessment is based on patient symptoms, interventions, and progress towards

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 405	Continued From page 206 goals....... Interventions are provided based on the patient's treatment plan for pain. ......The pain management/treatment plan is evaluated on an ongoing basis and is revised to facilitate achievement of pain goals based on best practices, patient's clinical condition, past medical history, and pain goals......... Pain rating must be documented prior to the administration of PRN pain medication. If opioids are administered, sedation level must also be documented. Pain rating and sedation levels are reassessed within 1 hour after PRN pain administration by any route. If opioids are administered, sedation is evaluated to assess for opioid-induced respiratory depression using one of the following sedation scales: 1. For the non-ICU, non-intubated patient (adult and pediatric), the Pasero Opioid-Induced Sedation Scale (POSS) should be used. ..... The pain/treatment plan is evaluated on an ongoing basis and is revised to facilitate achievement of pain goals. " Review of a "Medication Administration" policy revised 03/20/2023 revealed, ".....Pain medications may be administered to treat or prevent pain. Proactive pain management is preferred to reactive......For opioid medications ordered "as needed for pain" the level of pain for administration must be specified in the order. 1. If the patient's symptom is unrelieved, the nurse may administer additional doses of PRN (as needed) medications ordered, not to exceed the maximum dose within the prescribed frequency. 2. Subsequent doses are based on the nurse's assessment, the patient's response to the previous dose, absence of adverse effects, and symptom severity. ..... Monitor the patient's response....."	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 405	Continued From page 207 1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .. " Review revealed a pain level reported as 2 (scale 1-10 with 10 the worst). Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to administer a dose of aspirin. A baby aspirin was administered as ordered at 1334. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. Interview on 12/09/2023 at 1210 with Assistant Director of Nursing (ADON) #17 revealed no nursing assessments or reassessments were	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 405	Continued From page 208	A 405		

documented in the ED record.
2. Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of dizziness. Review revealed a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the Registered Nurse (RN) #3 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). At 2329 Hospitalist Medical Doctor (MD) #9 ordered an IV infusion of D5 1/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). At 0157 RN #10 documented the IV with D5 1/2 NS KCL as started (2 hours and 27 minutes after ordered).

Interview on 12/08/2023 at 1425 with RN #3 who cared for Patient #83 on 11/28/2023 revealed physician orders were not followed for Patient #83.

Interview on 12/08/2023 at 1230 with Nursing Vice President (VP) of ED Services, VPED #20 revealed hospital policy was not followed for Patient #83.

3. Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 405	Continued From page 209 week. Drinks 12 beers a day...." Patient #43 was assigned to ED Medical Doctor (MD) #23. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4 mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed ". I have ordered IV (intravenous) fluids. 1 mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating). Hospitalist has been consulted for admission. " At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, and thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately). At 1851 the GI Cocktail and Zofran were administered. At 1947 MD #23 ordered Ativan 1 mg IV push NOW (urgent). At 2100 a multivitamin orally was ordered. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT. No medication administrations, IV access/fluids, or physician orders were completed after 1851 (when the GI Cocktail and Zofran was administered) for Patient #43 while in the ED waiting room. At 0105 MD #25 ordered Patient #43 to have Ativan 4 mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 405	Continued From page 210	A 405		

(emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. .." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841, Ativan IV NOW ordered on 08/14/2023 at 1947, and Phenobarbital STAT ordered on 08/14/2023 at 2305 for Patient #43 were delayed.

Interview on 11/15/2023 at 1615 with NP #36 revealed ". it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. " Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED Internal Processing Area (IPA) Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment. " Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 405	Continued From page 211 the IPA area go by priority and ESI (Emergency Severity Index ESI - score to determine patients with most to least urgent needs), we are not always able to do them. The CNC (Clinical Nurse Coordinator should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's providers orders had not been completed.	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 405	Continued From page 212 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed "...the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed...The Head CT was negative...Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes...We have been running norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted...." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4 mg in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20 mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 405	Continued From page 213	A 405		

was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate)...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040..."

Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 405	Continued From page 214 assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (Physician's Assistant PA #77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 405	Continued From page 215 notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU, a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his	A 405		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 405	Continued From page 216	A 405		

patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation.

Request to interview ED RN #68 revealed she was not available for interview.

Request to interview ED RPH #78 revealed she was unavailable for interview.

Request to interview ED Manager RN #75 revealed he was unavailable for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 405	Continued From page 217 Request to interview ED Director, RN #76 revealed she was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 405	Continued From page 218	A 405		

acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available for this surveyor).

Interview on 11/15/2023 at 1637 with VPED #20 revealed hospital policy for Patient #28 was not followed.

Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 405	Continued From page 219	A 405		

Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did.

5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 with a pain score of 10 (1 least pain and 10 being the most pain). At 0028 Nurse Practitioner (NP) #39 wrote orders for an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were

A 405

Continued From page 220

administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction.

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed physician orders were not completed in the ED waiting room in 2022.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed...There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds...things are not happening on a timely basis..." Interview revealed Patient #27 did not get medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.

6. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity

A 405

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 405	Continued From page 221	A 405		

and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention".

Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...".

Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 405	Continued From page 222 consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	A 405		
A 449	CONTENT OF RECORD CFR(s): 482.24(c) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on review of hospital staff orientation/competency training, medical record review, and staff interviews, hospital staff failed to document baths and/ or linen changes had been performed to meet patient activity of daily living needs in seven (7) of 56 sampled inpatient patient records reviewed (Patient #'s 55, 64, 90, 81, 60, 40, and 26).	A 449	**Subject of Deficiency – A 449** Hospital staff failed to document baths and/ or linen changes had been performed to meet patient activity of daily living needs. **Plan of Correction:** **Education:** Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. **Education has been incorporated into**	

new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- Inpatient RN, LPN and PCT staff (excluding NICU and procedural areas) remedial education on activities of daily living (ADLs) expectations and documentation.

Actions:

- Developed daily report to drive compliance with documentation of ADLs.

Monitoring for Compliance:
The department nursing leader will audit for compliance with hygiene documentation.

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO

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A 449	Continued From page 223 The findings included: On 12/08/2023 at 0911 review of hospital documentation titled "Preceptor Guide Patient Care Tech (PCT) Staged Orientation" last updated 04/15/2022 revealed the "Preceptor Guide Provides detailed instructions for what the orientee must do for items to be checked off as 'met.'" Further review revealed the orientation stages ranged from 0 through 2. Stage 1 focused on basic patient care and procedures which included documentation. Stage 2 focused on "Routine Application: Provision of Patient Care" which included "Safely and reliably performs routine daily care for a variety of patient populations" and "Anticipates basic potential patient needs." Review revealed in stage 1 of orientation the orientee was expected to meet the following objectives: "Objective that needs to be Met ...Contributes to a healing environment ...Changes linen as indicated (includes occupied / unoccupied bed changes) ..." The orientee expected to meet "Documents activities / care in the EHR (Electronic Health Record) with preceptor assistance" which included "ADL (Activity of Daily Living". Stage 2 for routine application included "providing information related to ADLs and other care to patient ...Prepares in advance to answer questions about topics such as ADLs" Review revealed the skills with "(**)" indicated the skills "are essential items to onboarding and should be completed with orientee to successfully prepare them in patient care." Further review revealed the orientee assisted with ADLs which included "Hygiene Care** ...Bed bath, Shower and linen change." On 12/08/2023 at 0911 review of hospital	A 449		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A 449	Continued From page 224 documentation titled "Preceptor Guide Medical Surgical RN Staged Orientation" last updated 04/15/2022 revealed the staged orientation grid was divided into stages 0 through 4. Stage 4 "Preceptor Guide Provides detailed instruction for what the orientee must do for items to be checked off as 'met'" Further review revealed in the "Stage 1 - SKILL BUILDING" the preceptor was to "show" the orientee "how to document routine Activities of Daily Living (ADLs) in the EHR." On 12/08/2023 at 0911 review of hospital documentation titled "New Employee Orientation" module revealed "Cerner (hospital electronic system) Training for the PCT included "Documenting ADL's" 1. Closed medical record review on 12/05/2023 for Patient #55 revealed on 05/17/2023 at 1638 a 74 year old male arrived in the ED with SOB (shortness of breath). The admission H&P dated 05/17/2023 at 2100 by NP #29 revealed Patient #55 was seen earlier the same day at an outside hospital. The H&P included sarcoidosis diagnosed two years ago and during the last 3-4 days Patient #55 experienced a productive cough with increased SOB. The patient was transferred from the ED to a Medical Surgical Unit room 445 and remained assigned to the room until discharge on 06/06/2023 at 1115. Review revealed there was no documentation that Patient #55 was provided, offered or refused a bath for 16 days or that Patient #55 was provided, offered or refused linen changes x 14 days. On 12/05/2023 request made to interview CNA that provided care for Patient #55. On 12/06/2023 at 1115 it was revealed the CNA was not	A 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A 449		A 449		

Continued From page 225
available.

Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff was expected "to document" performed ADLs.

Interview on 12/08/2023 at 1403 with (Certified Nurse Aide) CNA #33 revealed she offered baths every day and as needed. She stated "especially" if the patient was able to take a shower. CNA #33 revealed she charted when the task was done.

Interview on 12/08/23 at 1448 with CNA #34 revealed patient baths can be given day or night shift. She revealed she checked the chart at the beginning of her day shift to see the number of patients that needed baths. Interview revealed that CNA #34 documented baths right away once done but if she did not have time, she would write the task down on paper and document the task later.

Interview on 12/08/2023 at 0911 with the Director of Clinical Education (DCE) #36 revealed PCT was the same as CNA. She revealed there was not a policy regarding when baths or a change of linen was offered. She revealed that upon hire PCTs were oriented by preceptors which included baths, linen change and documentation once the task was completed. The orientation continued on the assigned unit and a face-to-face with the hospital EMR (Electronic Medical Record) system. DCE #36 stated "the annual competencies may not be the same for each unit because it depends on the needs of that unit."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A 449	Continued From page 226 2. Closed medical record review on 12/06/2023 for Patient #64 revealed on 08/30/22 at 1547 a 36 year old male arrived in the ED with upper back pain. Review of a progress note dated 08/31/2023 at 1240 by PA #31 revealed per a Radiologist Patient #64 had osteomyelitis to C6-C7 with discitis (inflammation to the disc between the spinal vertebrae - bones). An epidural abscess was present with spinal cord compression that extended from CT to T1 (pressure to the top of the neck-cervical segment to the thoracic segment - chest portion of the spinal cord). A neurosurgery consultation was made for likely urgent surgical intervention. Further review revealed on 08/31/2022 Patient #64 had an emergency "Anterior Cervical Discectomy" spinal surgical procedure. Review of a progress note dated 12/12/2022 at 1419 by an ID (infectious disease) MD revealed Patient #64 remained "profoundly debilitated and with neurologic deficits; he is currently paraplegic but also has upper extremity strength issues." Patient # 64 was assigned to the Pulmonary unit Date: 10/09-15/2022. Review revealed there was no documentation the patient was offered or refused linen changes x 6 days. Patient #64 was assigned to the K-Spine unit, Date: 10/19-26/2022. Review revealed there was no documentation that Patient #64 was provided, offered or refused a bath x 6 days or that Patient #64 was provide, offered or refused a linen change x 5 days for sample week. Patient #64 was assigned to a Med Surg/Telemetry unit, Date: (11/13-19/2022) and (12/25-31/2023) and the patient required total assistance. Review revealed there was no documentation that Patient #64 was provided, offered, or refused baths x 6 days or was provided, offered or refused a linen change x 4 days for the first sample week. Review revealed	A 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 449	Continued From page 227	A 449		

there was no documentation that Patient #64 was provided, offered or refused baths x 5 days or was provided, offered or refused linen change x seven days for the second week. Patient #64 was assigned to the Neuro unit, Room A611, Dates: 01/06-31/2023 and 02/19-25/2023. Review revealed there was no documentation that Patient #64 was provided, offered or refused a bath x 23 days or provided, offered or refused linen changes x 5 days for the first sample week. Review revealed there was no documentation that Patient #64 was provided, offered or refused baths x 5 days or provided, offered or refused linen changes for the second sample week.

Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff was expected "to document" performed ADLs.

Interview on 12/08/2023 at 1403 with (Certified Nurse Aide) CNA #33 revealed she offered baths every day and as needed. She stated "especially" if the patient was able to take a shower. CNA #33 revealed she charted when the task was done.

Interview on 12/08/23 at 1448 with CNA #34 revealed patient baths can be given day or night shift. She revealed she checked the chart at the beginning of her day shift to see the number of patients that needed baths. Interview revealed that CNA #34 documented baths right away once done but if she did not have time, she would write the task down on paper and document the task later.

Interview on 12/08/2023 at 0911 with the Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 449	Continued From page 228	A 449		

of Clinical Education (DCE) #36 revealed PCT was the same as CNA. She revealed there was not a policy regarding when baths or a change of linen was offered. She revealed that upon hire PCTs were oriented by preceptors which included baths, linen change and documentation once the task was completed. The orientation continued on the assigned unit and a face-to-face with the hospital EMR (Electronic Medical Record) system. DCE #36 stated "the annual competencies may not be the same for each unit because it depends on the needs of that unit."

3. Review of closed medical record revealed Patient #90, a 57 year old female arrived to the hospital on 07/05/2022 for a scheduled surgical total hip arthroplasty (total hip surgical replacement) for continued failed treatment for hip osteoarthritis (degeneration of cartilage and the underlying bone). Review of physician post-surgical orders revealed Patient #90 could shower after surgery. Review of documentation of baths revealed Patient #90 did not receive a bath or shower on 07/06/2022, 07/07/2022, 07/08/2022, 07/09/2022, 07/10/2022, and 07/11/2022, a total of 6 days. Patient #90 was discharged on 07/13/2022.

Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff were expected "to document" performed ADLs (activities of daily living--baths or showers).

4. Closed medical record review revealed Patient #81 was admitted on 09/20/2023 at 1445 with a presenting chief complaint of shortness of breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 449	Continued From page 229	A 449		

Review of the Nursing Flowsheet, revealed on 09/20/2023 no evidence of assistance with activities of daily living on the Medical Cardiology Stepdown unit when patient arrived onto the unit at 2144. On 09/21/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/22/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/23/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/24/2023, 0700 through 1900 (12 hours), RN #4 provided primary nursing care to Patient #81, which failed to reveal evidence of a bath offer/decline or linens changed. On 09/26/2023 review failed to reveal evidence of a bath offer/decline or linens changed. Patient #81 was discharged on 09/26/2023 at 0759 to the skilled nursing facility.

Interview with an RN #82 on 12/05/2023 at 1115 revealed, it was the expectation of the facility staff to document that patients were offered or declined daily hygiene opportunities and linen changes in the medical record every 24 hours.

Interview with RN #4 on 12/07/2023 at 0955 revealed, it was the expectation of the facility staff that patients were to be offered and documented daily hygiene opportunities and linen changes in the medical record every 24 hours. Interview revealed it was the Registered Nurse to oversee the completion of the task of bathing opportunities, linens changed as part of activities of daily living.

5. Review on 11/28/2023 of the closed medical record for Patient #60 revealed a 63-year-old female that presented to the Emergency Department on 10/31/2022 at 1101 with a chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 449	Continued From page 230	A 449		

complaint of chest pain. Patient #60 was admitted to inpatient services on 10/31/2022 at 1646 and discharged on 11/18/2022 at 1556. Review of the nursing notes from 10/31/2022 through 11/18/2022 revealed that Patient #60 was assisted with a bath on 11/03/2022, refused bath on 11/04/2022 and 11/15/2022, basin wipes bath on 11/16/2022 and performed bath independently on 11/17/2022. Documentation failed to reveal evidence that Patient #60 received a bath on 11/01, 11/02, 11/05, 11/06, 11/07, 11/08, 11/09, 11/10, 11/11, 11/12, 11/13, 11/14 and 11/18/2022 (13 of 18 days with no documented bath).

Interview on 12/01/2023 at 0945 with NM #85 and NM #86 revealed the staff were expected to document that patients were offered or refused a daily bath in the medical record every 24 hours.

6. Closed medical record review on 11/14/23 for Patient #40 revealed on 3/4/2023 at 1747 an 84 year old male with a history of Alzheimer's presented with increasing weakness and confusion. Patient #40 remained in the Emergency Department (ED) until being admitted from 3/5/23 at 0216 until discharge to a nursing facility on 3/8/23 at 1722. There was no documentation to reflect an offer/decline of a bath during this 4-day time period.

Closed medical record review on 11/14/23 for Patient #40 revealed on 4/28/23 at 0226 the 84-year-old male with a history of Alzheimer's was transported to the ED via ambulance after falling at a local pharmacy. Patient #40 was diagnosed with COVID requiring supplemental oxygen then admitted to the facility on 4/29/23 at 0709. Patient #40 remained in the facility until discharge to a nursing facility on 5/9/23 at 1021. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A 449		A 449		

Continued From page 231

documentation to reflect an offer/decline of a bath for the 11-day admission. During the same 11-day admission, there were no documented linen changes with the exception of "no" being documented on 5/5/23 at 0442 and 2000.

Interview with RN #81 on 11/14/23 at 1200 confirmed the expectation for nursing to offer and document bathing and linen changes in the medical record.

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7. Review on 11/16/2023 of the "Staffing Responsibilities and Procedure" policy revised 02/10/2015 revealed, "Policy: Mission Hospital will maintain staffing to meet patient care needs on all nursing units...".

Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review revealed the patient was transferred from the ED to unit B3-South (3rd floor holding area) on 09/02/2022 at 1915. Review of closed medical record lacked nursing documentation related to patient assistance with toileting while located on unit B3-South from 09/02/2022 through 09/03/2022. Review revealed the patient was transferred from unit B3-South to unit A5-West room #566 on 09/03/2022 at 1357. Review of closed medical record lacked nursing documentation related to patient assistance with bathing (shower/bath) and hygiene needs from 09/03/2022 through 09/07/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 449	Continued From page 232 Interview on 11/14/2023 at 1545 with RN #101 revealed unit B3-South (3rd floor holding area) is currently not being utilized as a patient care unit. RN #98 revealed during Patient #26's hospital admission starting on 09/02/2022, unit B3-South was a "holding unit" for patients between the ED and admission to an inpatient bed. RN #98 revealed patient rooms on the unit did not have bathrooms in the rooms and patients would have to walk to a bathroom located in the hallway. RN #98 revealed nursing staff should have assisted patients with toileting and/or ambulating to the hallway bathroom. Interview on 11/16/2023 at 1130 with PCT #99 (Patient Care Technician) while on tour of unit A5-West indicated that he/she assists patients with ADL's (Activities of Daily Living) such as bathing, toileting, and oral care. PCT #99 stated that patients located in even room numbers are assisted with bathing on the dayshift and patients located in odd room numbers are assisted with bathing on the nightshift. PCT #99 stated the unit is often staffed with 1 PCT for up to 36 patients making it difficult to provide care in a safe and timely manner to all patients. Interview on 11/16/2023 at 1200 with RN #97 (Director) indicated unit A5-West has 36 patient beds which ideally was staffed with 7 RN's, 2 PCT's and 1 unit clerk. RN #97 revealed fully staffing the unit was often a challenge.	A 449		
A 576	LABORATORY SERVICES CFR(s): 482.27 The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all	A 576	**Subject of Deficiency – A 576** The hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department.	

Plan of Correction:

Education:

- ED Staff were educated on laboratory Turn Around Time (TAT) collection time goals
- Laboratory staff education on new analyzer functionality to increase automation

Actions:

- Reviewed and implemented phlebotomy staffing needs during surge times in ED
- ED CNC/ED Leadership oversight of lab collection times and escalation via internal communication tool
- Expansion of Laboratory space to improve automation of services to decrease delays in turnaround times
- Reviewed new area plan to create efficiencies in workflow by positioning techs around the analyzers, allowing techs to communicate timely and work together to complete tasks faster and reduce TATs
- Adding new analyzer functionality to all analyzers that will increase automation and lower TATs

Monitoring for Compliance:

Monitoring and tracking of specimens received to verify timeliness per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 70 audits/month
- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Operating Officer/COO

Monitoring and tracking of ED laboratory order to collect times through retrospective chart review

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 70 audits/month

- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO

(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) COMPLETION DATE
A 576	Continued From page 233 laboratory services provided to its patients are performed in a facility certified in accordance with Part 493 of this chapter. This CONDITION is not met as evidenced by: Based on policy review, medical record reviews, and staff interviews the hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department (ED) (Patient #'s 83, 27 and 2) and failed to ensure laboratory results were timely for three (3) of three (3) patients (Patient #'s 11, 93, and 94). The findings included: The hospital failed to have available laboratory services to meet the identified turn around times for STAT results for three (3) of 35 patients presenting to the hospital's emergency department (Patient #'s 83, 27, and 2), and failed to ensure timely laboratory results for three (3) of 3 patients that had lab specimens sent to Hospital A's lab from Hospital B (Patient #'s 11, 93 and 94). Cross refer to §482.27 Laboratory Services Standard: Tag A 0583.	A 576		
A 583	EMERGENCY LABORATORY SERVICES CFR(s): 482.27(a)(1) Emergency laboratory services must be available 24 hours a day. This STANDARD is not met as evidenced by: Based on policy review, medical record review, incident report review, laboratory logs, documents	A 583	**Subject of Deficiency – A 583** The hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department. Each individual Condition of Participation plan of correction for the cross-referenced tag in this section are outlined below. **Plan of Correction:** **Education:** • ED Staff were educated on laboratory Turn Around Time (TAT) collection time goals • Laboratory staff education on new analyzer functionality to increase automation	 2/6/24 2/16/24

Actions:

- Reviewed and implemented phlebotomy staffing needs during surge times in ED — 12/2/23
- ED CNC/ED Leadership oversight of lab collection times and escalation via internal communication tool — 12/2/23
- Expansion of Laboratory space to improve automation of services to decrease delays in turnaround times — 2/6/24
- Reviewed new area plan to create efficiencies in workflow by positioning techs around the analyzers, allowing techs to communicate timely and work together to complete tasks faster and reduce TATs — 2/6/24
- Added new analyzer functionality to all analyzers that will increase automation and lower TATs — 2/16/24

Monitoring for Compliance:

Monitoring and tracking of specimens received to verify timeliness per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits Denominator = 70 audits/month
- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Operating Officer/VP Operations

Monitoring and tracking of ED laboratory order to collect times through retrospective chart review

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits Denominator = 70 audits/month
- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A 583	Continued From page 234	A 583		

and staff interview, the hospital failed to have available laboratory services to meet the identified turn-around times for STAT (immediate) results for three (3) of 35 patients presenting to the hospital's Emergency Department (ED) (Patient #'s 83, 27, and 2), and failed to ensure timely laboratory results for three (3) of three (3) patients that had lab specimens sent to Hospital A's lab from Hospital B (Patient #'s 11, 93 and 94).

The findings included:

A. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of

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A 583	Continued From page 235	A 583		

receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. "

1. Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218. Labs were drawn at 1358. Labs arrived at the lab at 1412 and resulted at 1532 (1 hour and 20 minutes after arriving to lab, 3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. At 0529 the original lactic acid NOW, order was canceled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.

Review of Patient Safety Analysis completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was

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A 583	Continued From page 236 "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work. Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed. Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have trouble getting in contact with the phlebotomist. That morning they were not logged into to their IMobile device. I called the general lab number, and no one answered. I then contacted my house supervisor,	A 583		

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A 583	Continued From page 237	A 583		

and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy.

Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83.

2. Closed medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with abdominal pain reported as a pain level of 10 of

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A 583		A 583		

Continued From page 238

10. Orders for STAT lab work were placed at 0028. Lab results were completed at 0734 (7 hours and 6 minutes after ordered). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work.

Interview on 11/15/2023 at 1350 with ED Registered Nurse (RN) #38 who triaged Patient #27 revealed "... It's very possible that this patient waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed physician orders were not completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED Medical Doctor (MD) #26 revealed "...I saw the patient after she was roomed. ... There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. ... things are not happening on a timely basis. " Interview revealed hospital policy was not followed for Patient #27.

3. Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent".

Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed "... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath.

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A 583	Continued From page 239 ED record review revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs. Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." B. Review of policy Microbiology Turn Around	A 583		

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A 583	Continued From page 240 Times, Effective 05/30/2023, revealed "...III. POLICY A. Microbiology services are available 24/7. B. Specimens are received and processed on all 3 shifts. Microbiology Department: Test menu and turnaround time information. 17. Urine Culture a. Negative Culture: i. Non-invasive (i.e. clean catch & indwelling cath): 18-24 hours ii. Invasive: 48 hours b. Positive Culture: 24-48 hours ... " Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #11 revealed that a urine culture was submitted on 09/14/2023. The positive results were released on 09/19/2023 (four days after the specimen was received in the lab). Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #94 revealed that a urine culture was submitted on 09/06/2023. The positive results were released on 09/12/2023 (six days after the specimen was received in the lab). Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #93 revealed that a urine culture was submitted on 09/18/2023. The positive results were released 09/23/2023 (five days after the specimen was received in the lab). Review on 11/16/2023 of a log of all urine cultures processed by the Microbiology section from 09/23/2023 through 09/30/2023 revealed that 14 of 29 cultures, or 48%, were resulted at greater than 48 hours. Review of an email from a Laboratory	A 583		

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A 583	Continued From page 241 Microbiology Manager on 11/15/2023 at 1121 revealed "...There were delays in getting these finalized due to critical staffing in Microbiology. The decision was made on 09/19/2023 to start sending all of (named Hospital) to (Named outpatient Laboratory Company) since we didn't have the staff to read all cultures. The staff had to prioritize cultures. Outpatients were not looked at on a daily basis. They had to prioritize inpatients and critical specimen types such as blood cultures. However, they did sub the organisms each day to make sure they were viable to do identification and susceptibility testing." Request for interview with the Laboratory Microbiology Manager revealed they were unavailable. Telephone interview on 11/17/2023 at 0959 with the North Carolina Division Director of Laboratory revealed that during September 2023, the hospital microbiology department was experiencing critical staffing problems due to vacancies and staff on medical leave. The Director stated that on 10/02/2023, it was decided to use an outside Laboratory company to handle microbiology cultures. The Director also stated that at the same time, the department focused on staffing, hiring travelers and training on new processes. The Director stated that on November 6th, 2023, the hospital inpatient cultures were returned to in-house processing. The Director stated the Quality dashboards were being created to monitor turnaround times for cultures going forward.	A 583		
A1100	EMERGENCY SERVICES CFR(s): 482.55	A1100	**Subject of Deficiency – A 1100** The hospital staff failed to have effective emergency services to meet the needs	

of patients that presented to the Emergency Department.

Plan of Correction:
Immediate Actions Taken
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process
  - 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. — 12/1/23
  - 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage — 12/1/23
  - 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool.
- Arrival to EKG-10 min
  - 12/1/2023 Staff education with attestation — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders involving ED CNC/ED leadership oversight.
- Post Medication Administration Assessment Completed as indicated

Plan of correction	Completion date
o 12/2/2023 Staff education with attestation	12/2/23
o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.	
• Order to lab draw-30 minutes	
o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight.	
• Provider response to emergent needs when escalated	
o 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED	12/2/23
• Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.	
o 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations	12/2/23
• ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons	
o 12/2/2023 EKG icon education boost	12/2/23
o 12/21/2023 Stethoscope icon	12/21/23
o 12/26/2023 Telemetry	12/26/23
• 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS	12/6/23
• 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).	
• 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient	12/6/23

access, performance improvement, to develop a process to off-load EMS

- 12/14/2023 Instituted rapid triage process
- 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput.
- 12/9/2024 Trial EMS off-load location set-up
- 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses — 12/12/23
- 12/13/2023 Trial EMS off-load process
- 12/14/2023 Tracking and trending of implementation of EKG orders — 12/14/23
- 12/20/2023 ED CMU escalation pathway education and implementation — 12/20/23
- 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. — 12/29/23

Ongoing Actions:

Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
  - 1/5/2024 direction was given for closed loop communication — 1/5/24

Plan of correction	Completion date
within 60 minutes of escalated barriers via internal communication tool	
• ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons	
o 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments	2/1/24
• 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include:	1/20/24
o 1/25/2024 Modification of HCG order process to streamline results	1/25/24
o 1/30/2024 Structured communication to close loop on identified opportunities for improvement	1/30/24
o 1/30/2024 Standardized process to facilitate patient readiness for CT	1/30/24
• 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS	1/22/24
• 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours	
• 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.	
• 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design	1/30/24
o 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours	1/5/24
o 1/5/2024 Developed triggers for triage escalation and posted at triage desk	1/5/24
o 1/5/2024 Assessment/Re-assessment policy review	1/5/24
o 1/11/2024 Due diligence walk through with ER Operations and IT	1/11/24
o 1/11/2024 Front-end multidisciplinary team design session	1/11/24
o 1/12/2024 Assessment/Re-assessment policy approved	1/12/24

by CNO and Nursing Operations Council

Action	Date
○ 1/12/2024 Staff participated in organization and set-up of Critical Supply Room	1/12/24
○ 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors	1/12/24
○ 1/13/2024 Mock set-up of room 32	1/13/24
○ 1/15/2024 Addition of script printer in room 115	1/15/24
○ 1/15/2024 IT refresh complete	1/15/24
○ 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG	1/16/24
○ 1/16/2024 Capital PO issued for 4 portable cardiac monitors	1/16/24
○ 1/16/2024 Added additional monitor to Air Traffic Control (ATC) desk to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals	1/16/24
○ 1/17-29/2024 Reconfigured front-end area	1/29/24
○ 1/17/2024 Per staff request, 3 additional vital sign machines provided	1/17/24
○ 1/17/2024 Front-end multidisciplinary team education and roles and responsibilities review	1/17/24
○ 1/18/2024 Front-end education of ER providers in January provider meeting by ER Medical Director	1/18/24
○ 1/23/2024 Standardization of supply carts	1/23/24
○ 1/18/2024 Confirmed Team Health Leadership participation during 1/30 go-live	1/18/24
○ 1/18/2024 Standardization and escalation of Pharmacy order verification under the MAR education	1/18/24
○ 1/18/2024 Worked with pharmacy to standardize medication storage units	1/18/24
○ 1/18/2024 Added medication refrigerator to the medication	1/18/24

storage unit

- 1/18/2024 Educate staff on defined roles/responsibilities and standard work flow — 1/18/24
- 1/19/2024 Designated location for discharge paperwork and standardized process — 1/19/24
- 1/22/2024 Streamlined laboratory process for COVID, Flu, and RSV to improve timeliness of results — 1/22/24
- 1/23/2024 Confirmed 100% of providers received education on front-end process re-design — 1/23/24
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- 1/29/2024 Increased staff efficiency by stocking blood culture bottles in all areas — 1/29/24
- 1/30/2024 Created intake teams to perform MSE, nursing documentation, and implement initial interventions in Internal Processing Area (IPA) — 1/30/24
- 1/30/2024 Deployed 4 portable cardiac monitors — 1/30/24

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Education provided to currently working eligible and targeted staff and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include

(7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

Action	Date
• 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals	12/2/23
• 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight	12/2/23
• 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals	12/2/23
• 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol	12/2/23
• 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment	12/14/23
• 12/21/2023 ED nursing staff education regarding telemetry order initiation	12/21/23
• 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process	12/21/23
• 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff	12/21/23
• 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway	12/21/23
• 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversations with nursing staff completed by education team	1/15/24
• 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order	1/18/24
• 1/18/2024 Provider education for front-end redesign	1/18/24
• 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles.	2/2/24

- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation

2/6/24

Monitoring for Compliance/Audit Details:
Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- Arrival to Triage Times for walk-in and EMS
- Arrival to EKG order-to-complete per policy/protocol
- Pain Medication assessment/ reassessment per policy/protocol
- CIWA assessments per policy/protocol
- Realtime escalation of patient safety concerns
- CT order to exam

Sustained Compliance Audits to Ensure POC is Effective:
Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to-completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant EKG order-to-completion per policy/protocol audits

Denominator = 70 audits/month

- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits
  Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits
  Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits
  Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review

- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP Emergency Services

(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) COMPLETION DATE
A1100	Continued From page 242 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on policy review, medical record review, incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, the hospital staff failed to have effective emergency services to meet the needs of patients that presented to the Emergency Department. The findings included: Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). Cross refer to §482.55 Emergency Services Standard: Tag 1101.	A1100		
A1101	ORGANIZATION AND DIRECTION CFR(s): 482.55(a) Organization and Direction. If emergency services are provided at the hospital -- This STANDARD is not met as evidenced by: Based on policy review, medical record review,	A1101	**Subject of Deficiency: A 1101** Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including laboratory, telemetry and medication orders.	

CIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

SUPPLIER: HOSPITAL AND ASHEVILLE SURGERY CE

STREET ADDRESS, CITY, STATE, ZIP CODE: 509 BILTMORE AVE, ASHEVILLE, NC 28801

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) COMPLETION DATE
	Continued From page 243 incident report review, EMS trip report review, and staff and provider interviews, Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). The findings included: Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS: ... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. 2. A comprehensive assessment, performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale,	A1101	**Plan of Correction:** **Immediate Actions Taken** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings: Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding. • Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process o 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. o 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage o 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support o 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool. • Arrival to EKG-10 min o 12/1/2023 Staff education with attestation o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders	12/1/23 12/1/23 12/1/23 12/1/23

involving ED CNC/ED leadership oversight.

- Post Medication Administration Assessment Completed as indicated
  - 12/2/2023 Staff education with attestation — 12/2/23
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.
- Order to lab draw-30 minutes
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight.
- Provider response to emergent needs when escalated
  - 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED — 12/2/23
- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
  - 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations — 12/2/23
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
  - 12/2/2023 EKG icon education boost — 12/2/23
  - 12/21/2023 Stethoscope icon — 12/21/23
  - 12/26/2023 Telemetry — 12/26/23
- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS — 12/6/23
- 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure

was in place through the implementation of the front-end redesign).

- 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS — 12/6/23
- 12/14/2023 Instituted rapid triage process — 12/14/23
- 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. — 12/14/23
- 12/9/2024 Trial EMS off-load location set-up
- 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses — 12/12/23
- 12/13/2023 Trial EMS off-load process
- 12/14/2023 Tracking and trending of implementation of EKG orders — 12/14/23
- 12/20/2023 ED CMU escalation pathway education and implementation — 12/20/23
- 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. — 12/29/23

Ongoing Actions:

Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics

and escalations via internal communication tool.

- 1/5/2024 direction was given for closed loop communication within 60 minutes of escalated barriers via internal communication tool — 1/5/24
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
  - 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments — 2/1/24
- 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include: — 1/20/24
  - 1/25/2024 Modification of HCG order process to streamline results — 1/25/24
  - 1/30/2024 Structured communication to close loop on identified opportunities for improvement — 1/30/24
  - 1/30/2024 Standardized process to facilitate patient readiness for CT — 1/30/24
- 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS — 1/22/24
- 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours — 1/26/24
- 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.
- 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design — 1/30/24
  - 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours — 1/5/24
  - 1/5/2024 Developed triggers for triage escalation and posted at triage desk — 1/5/24
  - 1/5/2024 Assessment/Re-assessment policy review — 1/5/24
  - 1/11/2024 Due diligence walk through with ER Operations and IT — 1/11/24
  - 1/11/2024 Front-end — 1/11/24

multidisciplinary team design session

- 1/12/2024 Assessment/Re-assessment policy approved by CNO and Nursing Operations Council — 1/12/24
- 1/12/2024 Staff participated in organization and set-up of Critical Supply Room — 1/12/24
- 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors — 1/12/24
- 1/13/2024 Mock set-up of room 32 — 1/13/24
- 1/15/2024 Addition of script printer in room 115 — 1/15/24
- 1/15/2024 IT refresh complete — 1/15/24
- 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG — 1/16/24
- 1/16/2024 Capital PO issued for 4 portable cardiac monitors — 1/16/24
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Owner: Chief Nursing Officer/ACNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A1101	Continued From page 244 allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the patient will need to wait in the lobby. While in the lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines….."	A1101		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A1101	Continued From page 245 Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. ....The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated and immediate life-threatening needs are determined with appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial, physiological, and age-specific needs of the individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 246	A1101		

indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...."

1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and labs including CBC, chemistry, lipase and troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 247 abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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A1101	Continued From page 248 Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization. ..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis of STEMI (ST elevation myocardial infarction), Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR.	A1101		

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A1101	Continued From page 249 Interview on 12/09/2023 at 1210 with ADON #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented. 2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A1101	Continued From page 250 Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. " Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of dizziness from her doctor's office. Patient #83 was seen by an ED MD #1 on arrival and at 1218	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A1101	Continued From page 251 a comprehensive metabolic panel (CMP) [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 RN #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an inpatient bed. At 2329 Hospitalist MD #9 ordered an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution).	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 252 On 11/29/2023 at 0127 MD #9 ordered a Lactic Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these , later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 cancelled the 0127 NOW Lactic Acid order "nurse collect" from the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes after ordered) with result of 12.3 (normal high range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 253 in the lab for processing at 0907, and resulted at 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337. Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 254 from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work. Request to interview MD #9 revealed she was unavailable for interview. Request to interview MD #16 revealed he was unavailable for interview. Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed. Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble getting in contact with the phlebotomist. That morning they were not logged into to their imobile device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me 'we don't have another	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 255	A1101		

option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I strongly advocated for her to get moved into a bed with the CNC (clinical nurse coordinator), and it didn't happen. She didn't think it was a big deal.

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A1101	Continued From page 256 We don't have the capability to link the patient to a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83. Interview on 12/08/2023 at 1230 with Nursing Vice President of ED Services, RN #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83. Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83. Patient #83 was presented to the ED with	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 257 dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol Withdrawal Plan, effective date 07/20/2022 revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less than) 15..." The CIWA/Alcohol Withdrawal Plan	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 258 Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10.Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..." Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, ekg, and chest Xray were completed, and Patient #43 was assigned to ED Medical Doctor (MD) #23. Review of the ER Physician Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, ekg and chest Xray results from 08/14/2023 did not show any critical	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 259 results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and a CIWA Scale reassessment was due to be completed per protocol. No nursing reassessments, medication administrations, IV access/fluids, or physician orders were completed	A1101		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 260 after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was documented before the patient had a seizure event with sustained head injury. There was no nursing reassessment, or nursing care after 08/14/2023 at 1851 by RN #22 until 08/15/2023 at	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A1101	Continued From page 261 0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at 0334 from the ED. Patient #43 was discharged home on 08/17/2023. Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to send out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload." MD #23 declined to be interviewed. Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be monitored ..." Interview revealed MD #26 had concerns for patient safety in the ED waiting room due to delays in patient monitoring.	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

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A1101	Continued From page 262	A1101		

Interview on 11/15/2023 at 1615 with NP #36 revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 263 doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43. Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not been completed. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain,	A1101		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 264	A1101		

Continued From page 264

nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury.

4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency severity index (ESI) of 1-Resusicitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG, lab work, chest Xray and CT (cat scan) of the head. At 1005 Haldol (given to treat severe behavior) 10 mg Intravenous was ordered by MD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A1101	Continued From page 265 #59 and given due to combativeness. Review of the ER Note by MD #59 dated 07/05/2023 at 1002 revealed ".....history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now,... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed.. The Head CT was negative. Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes. We have been running norepinephrine (given to sustain blood pressure)	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 266 through this...ICU (intensive care unit) has been consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no	A1101		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 267	A1101		

signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040.

Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
A1101	Continued From page 268 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 269 was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 270 documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation. Request to interview ED RN #68 revealed she was not available for interview. Request to interview ED RPH #78 revealed she was unavailable for interview. Request to interview ED Manager RN #75 revealed he was unavailable for interview. Request to interview ED Director, RN #76 revealed she was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already	A1101		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 271	A1101		

approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available during the survey).

Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said, 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull resources..." Further interview with CNC RN #74 revealed "...she had no concerns with nursing reassessments in the ED... that nursing

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 272 assignments in the Red Pod (where the most acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care. Interview on 11/15/2023 at 1637 VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed. Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 273 Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him. Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 274 the bag ran dry with subsequent cardiac arrest. 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 275	A1101		

order) were administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136.

Request for a Patient Safety Report (Incident Report) revealed there was not one available.

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 276 waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022. Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27. Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 277 patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management. 6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters. Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain medication, antibiotics, and lab work." PA #45 ordered X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients)	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 278 Hallway Bed 7. At 1517 Patient #29 was triaged by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2. 20g Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), RN #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5mg IV for a pain score of 10/10 and Zofran 4mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain reassessment was charted as 9/10 (no evidence of an oxygen reassessment). At 1748 the Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 279 tibial shaft fracture..." with plan for surgery to repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (no evidence of this in the record). She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at 1909. Review of the Patient Event Record dated 04/06/2022 at 0341 by Nursing/Surgical Services #54 revealed the event was "unexpected death"	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 280 date of event "04/05/2022 at 1903" with narrative "...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsive in hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to the event per the report. Trauma Nurse, RN #56 as unavailable for interview. Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital policy for reassessment was not followed for Patient #29. Telephone interview on 11/16/2023 at 1324 with MD #46 revealed she did not recall Patient #29.	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 281 Interview revealed "...monitoring of patients in hallway beds are a concern. Ideally every patient in the Red Pod should be on some sort of a monitor with a pulse oximeter. More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside. Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29. Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be placed on a cardiac monitor which showed asystole. At 1909 was the time of death pronounced with her daughter at the bedside. Interview revealed this event was reviewed by the Mortality and Morbidity which was comprised of	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 282 multiple providers and the MD who had completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.) Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing). 7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood thinners and 10 days post partum. What aspect of reason for visit is concerning to patient? : Stroke symptoms....... " Review of a MD "ER Report", service date/time 10/03/2023 at 1714,	A1101		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 283 revealed " ... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the fact the patient is 10 days postpartum which does place her at an elevated risk for ischemic CVA (stroke). Differential at this point would also include complex migraine,	A1101		

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A1101	Continued From page 284 preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke. ..... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most urgent transport)......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no obvious distress....report is as follows: .....Dx (Diagnosis): HTN (hypertension) crisis, Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and	A1101		

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A1101	Continued From page 285 weakness and tingling onset. ...10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and leg weakness along with a facial droop and neck pain. Vital signs continued approximately every 5 minutes, with the last recorded blood pressure 147/90 at 2215.	A1101		

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A1101	Continued From page 286 Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H .....ED Full Triage Arrival Mode - ED (Emergent) : EMS .....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital....." Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form. ... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry neurologist decision was made against using tPA (breaks down blood clots). She was transferred here for further stroke eval and MRI (magnetic resonance imaging). She was also notably hypertensive at outside hospital with blood pressure 160s systolic. She has also had some	A1101		

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A1101	Continued From page 287 headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here. Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop Preeclampsia...... " Record review failed to reveal acceptance and monitoring of Patient #6 by nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal	A1101		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 288 documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023. Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring. Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 289	A1101		

assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia.

Telephone interview with Patient #6's Triage Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation. Interview revealed the EMS team was responsible for any patient they brought in until the patient got a room assignment and was moved to a room in the ED. Once the patient was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 290 in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Telephone interview on 11/17/2023 at 1205 with Medical Doctor (MD) #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage,	A1101		

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A1101	Continued From page 291 assessment and monitoring by nursing staff. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed " ...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed "....History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)...... Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with neurologic symptoms concerning for acute ischemic stroke I think she will likely be a candidate for thrombolytics assuming that we can get her blood pressure down. She is going to CAT (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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A1101	Continued From page 292	A1101		

labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. ...." Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority.

Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). .....THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED ....THE PHYSICIAN ADVISED TARGET BLOOD PRESSURE IS 140/90 AND ADVISED TO MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 293 ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE..... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT.... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED..." Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and hand-off to the hospital. Review of the Hospital A medical record for Patient #1 revealed the patient arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351, revealed "	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1101	Continued From page 294 ... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management.....Physical Exam .... Initial Vitals No Data Available .... Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making ..... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ..." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated "....Impression and Plan: ... #ICH (Intracranial Hemorrhage): hypertensive etiology suspected..... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on one side of the body). Plan: admit to ICU for close neurologic monitoring. ....." Review of the ED record failed to reveal any vital signs or assessments by nursing. Review revealed "Nurse Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by (Name), RN. ED CNC	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 295 (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85. Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED. Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients in the ED as soon as they were notified of the patient's arrival. Interview revealed it was "surprising" not to have vital signs completed in the ED and stated it did not meet expectations for	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 296 care - patients needed hourly neuro checks and vital signs with provider updates on changes. Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible." Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 297 at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE BIG TOE OF HIS LEFT FOOT. IT WAS NOW NOTED THAT PT'S EKG WAS SHOWING ... ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 298 A&Ox4..... PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN. ....." EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care ......" Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 299	A1101		

Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7.

Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed " ... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks .....He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic , Diflucan (antifungal), and Duricef (antibiotic). ....Medical Decision Making...... EMS reports that they gave patient 324 mg aspirin...... blood pressure was approximately 96 mmHg. They gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that patient had 7 beat run of V tach on their EKG tracing in route with patient now in sinus rhythm and occasional bigeminy. Ordered EKG and for patient to be on telemetry .....Point-of-care CBG

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 300	A1101		

(blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach ....1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017 Called lab to request results of chemistries be available as soon as possible. Labs resulted after arrest .... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack).

Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A1101	Continued From page 301 and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm .....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For this patient who presented with chest pain, syncope, and suffered cardiac arrest has either suffered an MI or rhythm disturbance.....I reviewed his medications..... I made attempts to	A1101		

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	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 302 address .....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole .....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46 ... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest...." Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17 minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently and it seemed like a staffing issue. Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the patient came into the ED	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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A1101	Continued From page 303 with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival. Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient #2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in a room and care handed-off from EMS, interview revealed, they were "counting on EMS to care for (the patients)..."	A1101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	C 12/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
A1101	Continued From page 304 Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment. 10. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No	A1101		

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A1101	Continued From page 305 past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival). Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be seen by providers and prescribed medications while "on the wall" but can not get them because no RN has been assigned. 11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin"	A1101		

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A1101	Continued From page 306 policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention". Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...". Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was	A1101		

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A1101	Continued From page 307 completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Record review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	A1101		

Attachment 2:

CMS Revisit Survey Findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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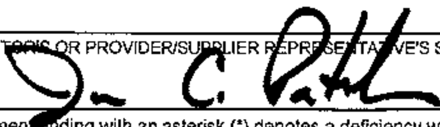
{A 000}	INITIAL COMMENTS An unannounced Revisit Survey (ASPEN #EEOP11) was conducted at the above-named Hospital from 02/20/2024-02/23/2024 for the purpose of removing the Immediate Jeopardy identified on 12/01/2023 and 12/09/2023 for failure to ensure a safe environment for the delivery of care to emergency department patients by failing to accept patients on arrival to the emergency department resulting in delays or failure to triage, assess, and implement orders; and failing to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department by failing to limit environmental risks in the Emergency Room Pods. Observations, interviews, document reviews and medical record reviews revealed that the hospital had implemented its IJ Removal Plan and the Immediate Jeopardy has been removed. The Hospital continues to be non-compliant with the conditions, 482.12 Governing Body, 482.13 Patient Rights, 482.21 Quality Assessment and Performance Improvement, 482.23 Nursing Services, 482.27 Laboratory Services, and 482.55 Emergency Services.	{A 000}		
{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...	{A 043}	**Subject of Deficiency – A 043** The hospital's governing body failed to provide oversight and have systems in place to ensure the protection and promotion of patient's rights to ensure a safe environment for emergency department patients; failed to maintain an organized and effective quality assessment and improvement program; failed to have an organized nursing service to meet patient care and safety needs and failed to meet the emergency needs of patients. Plan of Correction: The governing body of Mission Hospital is dedicated to the oversight of this plan of correction and the continued improvement required to facilitate the needs of our patients and the community. As such, the governing body is fully informed of the conditions of participation deficiencies cited herein and will continue with the oversight necessary to fully address these deficiencies. The governing body believes that the multidisciplinary leadership team used to formulate this plan of correction fully addressed all CMS tags identified as out of compliance and that there are system changes in place necessary to achieve continued compliance. The plan of correction demonstrates the facilities commitment to compliance with all applicable conditions of participation requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

(X6) DATE 3·13·24

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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{A 043}	Continued From page 1 This CONDITION is not met as evidenced by: Based on policy review, Quality Performance Improvement Plan review, medical record review, Emergency Medical Services (EMS) trip report review, incident report review, observations, environmental risk assessment review, pharmacy unit inspection review, personnel file review, hospital document review and staff and provider interviews, the hospital's governing body failed to provide oversight and have systems in place to ensure the protection and promotion of patient's rights to ensure a safe environment for emergency department patients; failed to maintain an organized and effective quality assessment and improvement program; failed to have an organized nursing service to meet patient care and safety needs and failed to meet the emergency needs of patients. The findings included: 1. The hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.12 Governing Body Standard: Tag A 0068. 2. The hospital's leadership failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the emergency	{A 043}	**Action:** The Chair of the Medical Executive Committee (MEC) and the MEC were informed of the survey deficiencies during the regularly scheduled committee meeting. The Mission Hospital Board of Trustee's (BOT) were notified of survey deficiencies and findings via e-mail on 2/2/24. **Monitor for Compliance:** The governing body will provide oversight of the plan of correction implementation and sustained improvements. All ongoing actions, monitoring activities and results will be reported monthly to the Quality Council and all other appropriate committees and the MEC/BOT (per individual schedules) beginning in February of 2024. If the team identifies significant variations in the POC the MEC/BOT will be informed as soon as possible and will review the appropriate course of action. This reporting structure will be maintained for at least 4 months and continue as indicated to maintain compliance. **Owner**: Chief Executive Officer/COO	2/2/24

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{A 043}	Continued From page 2 department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.12 Governing Body Standard: Tag A 0092. 3. The hospital staff failed to ensure a safe environment for behavioral health patients subject to self-harm in the ED by failing to limit environmental risks in the Emergency Room pods (cluster of rooms in a designated area) used to house Behavioral Health patients awaiting placement (Green Pod and Purple Pod). Cross refer to §482.13 Patient Rights' Standard: Tag A 0144. 4. The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for 7 of 94 sampled patients reviewed (#58, #27, #59, #50, #13, #50, #2). Cross refer to §482.21 Standard: QAPI Quality Improvement Activities, Tag A 0286. 5. The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action for 7 of 94 sampled patients	{A 043}	**Subject of Deficiency A 068:** The hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered. Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below **Plan of Correction:** **Immediate Actions Taken** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings: Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding. • Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process o 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. o 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage o 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support o 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool	12/1/23 12/1/23

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{A 043}	Continued From page 3 reviewed. (#58, #27, #59, #50, #15, #13 and #2). Cross refer to §482.21 Standard: QAPI Standard: Tag A 0309. 6. The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatment in the emergency department for 4 of 35 sampled ED records reviewed (Patients #28, #43, #27, and #2). Cross refer to 482.23 Nursing Standard: Tag A 0392. 7. The hospital's nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.23 Nursing Standard: Tag A 0398. 8. The hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered and evaluate and monitor the effects of the medication for 6 of 35 patients presenting to the emergency department (#92, #83, #43, #28, #27, and #26). Cross refer to §482.23 Nursing Standard: Tag A 0405.	{A 043}	• Arrival to EKG-10 min o 12/1/2023 Staff education with attestation o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders involving ED CNC/ED leadership oversight. • Post Medication Administration Assessment Completed as indicated o 12/2/2023 Staff education with attestation12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight. • Order to lab draw-30 minutes o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight. • Provider response to emergent needs when escalated o 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED • Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool. o 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations • ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons o 12/2/2023 EKG icon education boost o 12/21/2023 Stethoscope icon o 12/26/2023 Telemetry	12/1/23 12/2/23 12/2/23 12/2/23 12/2/23 12/21/23 12/26/23

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{A 043}	Continued From page 4 9. The hospital staff failed to have available laboratory services to meet the identified turn around times for STAT results for 3 of 35 patients presenting to the hospital's emergency department (#83, #27, #2), and failed to ensure timely laboratory results for 3 of 3 patients that had lab specimens sent to Hospital A's lab from Hospital B (#11, #93 and #94). Cross refer to §482.27 Laboratory Services Standard: Tag A 0583. 10. Emergency department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). Cross refer to §482.55: Emergency Services Standard Tag A 1101.	{A 043}	• 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS • 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign). • 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS 12/14/2023 Instituted rapid triage process • 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. • 12/9/2024 Trial EMS off-load location set up • 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses	12/6/23 12/7/23 12/6/23 12/14/23 12/14/23 12/12/23
{A 068}	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and	{A 068}	• 12/13/2023 Trial EMS off-load process • 12/14/2023 Tracking and trending of implementation of EKG orders • 12/20/2023 ED CMU escalation pathway education and implementation • 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in	12/14/23 12/20/23 12/29/23

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{A 068}

Continued From page 5

(ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is--
(A) Defined by the medical staff;
(B) Permitted by State law; and
(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

This STANDARD is not met as evidenced by:
Based on policy review, medical record review, Emergency Medical Services (EMS) trip report review, incident report review, and staff and provider interviews, the hospital's leadership failed to ensure a medical provider was responsible for monitoring and ensuring the delivery of care to patients presenting to the emergency department. Nursing staff failed to provide care to emergency department (ED) patients by failing to triage upon arrival, assess, monitor, and provide care and treatment as ordered for 11 of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26).

The findings included:

Review of the Quality Improvement Plan approved by the hospital Chief Executive Officer (CEO), Board of Trustees Chair and Chief Medical Officer (CMO) on 04/24/2023 revealed, " ...The hospital-wide Performance Improvement Plan is designed to improve quality performance and patient safety, ultimately reducing the risk to patients. ... ACCOUNTABILITY ... The following individual and/or committees are accountable for setting expectations, developing plans, and implementing procedures to assess, improve quality, and measure performance improvement

{A 068}

response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses.

Ongoing Actions:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
  - 1/5/2024 direction was given for closed loop communication within 60 minutes of escalated barriers via internal communication tool — 1/5/24
- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
  - 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments — 2/1/24
- 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include: — 1/20/24
  - 1/25/2024 Modification of HCG order process to streamline results — 1/25/24
  - 1/30/2024 Structured communication to close loop on identified opportunities for improvement — 1/30/24
  - 1/30/2024 Standardized process to facilitate patient readiness for CT — 1/30/24
- 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS — 1/22/24
- 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours — 1/26/24
- 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by — 1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 068}	Continued From page 6 within the organization........Medical Executive Committee ......Medical Staff / Medical Staff Department Chairman. The Medical staff shall be responsible to participate in the Performance Improvement Plan to the degree necessary and appropriate to achieve the purpose of the plan. Medical Staff members will be appointed to various Medical Staff Committees. These committees shall be responsible for implementing and maintaining an effective system to monitor and evaluate the quality and appropriateness of care...... The medical staff department chairs will participate in the Campus Executive Committee or Medical Executive Committee, as applicable. Participation will include monitoring metrics, developing criteria, evaluating results, ensuring resolution, and reporting findings to the appropriate medical staff department......" Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS:.... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. 2. A comprehensive assessment,	{A 068}	providing qualified personnel for ongoing rounding. • 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design o 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours o 1/5/2024 Developed triggers for triage escalation and posted at triage desk o 1/5/2024 Assessment/Re-assessment policy review o 1/11/2024 Due diligence walk through with ER Operations and IT o 1/11/2024 Front-end multidisciplinary team design session 1/12/2024 Assessment/Re-assessment policy approved by CNO and Nursing Operations Council o 1/12/2024 Staff participated in organization and set-up of Critical Supply Room o 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors o 1/13/2024 Mock set-up of room 32 o 1/15/2024 Addition of script printer in room 115 o 1/15/2024 IT refresh complete o 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG o 1/16/2024 Capital PO issued for 4 portable cardiac monitors o 1/16/2024 Added additional monitor to Air Traffic Control (ATC) desk to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals o 1/17-29/2024 Reconfigured front-end area	1/5/24 1/5/24 1/5/24 1/11/24 1/11/24 1/12/24 1/12/24 1/12/24 1/13/24 1/15/24 1/15/24 1/16/24 1/16/24 1/16/24 1/29/24

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{A 068}	Continued From page 7 performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale, allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the patient will need to wait in the lobby. While in the	{A 068}	o 1/17/2024 Per staff request, 3 additional vital sign machines provided o 1/17/2024 Front-end multidisciplinary team education and roles and responsibilities review o 1/18/2024 Front-end education of ER providers in January provider meeting by ER Medical Director o 1/23/2024 Standardization of supply carts o 1/18/2024 Confirmed Team Health Leadership participation during 1/30 go- live o 1/18/2024 Standardization and escalation of Pharmacy order verification under the MAR education o 1/18/2024 Worked with pharmacy to standardize medication storage units o 1/18/2024 Added medication refrigerator to the medication storage unit o 1/18/2024 Educate staff on defined roles/responsibilities and standard work flow o 1/19/2024 Designated location for discharge paperwork and standardized process o 1/22/2024 Streamlined laboratory process for COVID, Flu, and RSV to improve timeliness of results o 1/23/2024 Confirmed 100% of providers received education on front-end process re-design o 1/24/2024 Front-end multidisciplinary team Go/No Go meeting with decision to move forward o 1/25/2024 Launch discharge print button to support greater efficiency for the providers to print discharge instructions o 1/26/2024 Greet tracker installed in provider area o 1/26/2024 Streamlined laboratory process to expedite results for HC	1/17/24 1/17/24 1/18/24 1/23/24 1/18/24 1/18/24 1/18/24 1/18/24 1/18/24 1/19/24 1/22/24 1/23/24 1/24/24 1/25/24. 1/26/24 1/26/24

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{A 068} Continued From page 8

lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines. ....."

Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. .... The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated, and immediate life-threatening needs are determined with appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial, physiological, and age-specific needs of the

{A 068}

HCG

- 1/26/2024 6 workstations on wheels (WOW) deployed for provider and CNC documentation efficiency (decreased time from arrival to first clinical order) — 1/26/24
- 1/29/2024 Increased staff efficiency by stocking blood culture bottles in all areas — 1/29/24
  1/30/2024 Created intake teams to perform MSE, nursing documentation, and implement initial interventions in Internal — 1/30/24
- Processing Area (IPA)
- 1/30/2024 Deployed 4 portable cardiac monitors — 1/3/24

Education:
Education provided to currently working eligible and targeted staff and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals — 12/2/23
- 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight — 12/2/23
- 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals — 12/2/23
- 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol — 12/2/23

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{A 068}

Continued From page 9

individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...."

1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and labs including CBC, chemistry, lipase and

{A 068}

- 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment — 12/14/23
- 12/21/2023 ED nursing staff education regarding telemetry order initiation — 12/21/23
- 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process — 12/21/23
- 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff — 12/21/23
- 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway — 12/21/23
- 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversation with nursing staff completed by education team — 1/15/24
- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front- end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24
- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation — 2/6/24

Monitoring for Compliance/Audit Details:

Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:
- Arrival to Triage Times for walk-in and EMS
- Arrival to EKG order-to-complete per policy/protocol
- Pain Medication assessment/ reassessment per policy/protocol

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{A 068}	Continued From page 10 troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed	{A 068}	• CIWA assessments per policy/protocol • Realtime escalation of patient safety concerns • CT order to exam Sustained Compliance Audits to Ensure POC is Effective: Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS) • The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant arrival-to triage times per policy/protocol • Denominator = 70 observation per month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring and tracking of EKG order-to- completion per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant EKG order- to-completion per policy/protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters	

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{A 068}

Continued From page 11

no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization. ..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis of STEMI (ST elevation myocardial infarction),

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- Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

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{A 068}

Continued From page 12

Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR.

Interview on 12/09/2023 at 1210 with ADON #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor.

Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to ensure a safe environment for the delivery of care to Patient #92 by failing to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry.

2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and

{A 068}

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ Chief Medical Officer/ACNO/VP Emergency Services

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{A 068}	Continued From page 13 efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. " Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of	{A 068}		

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{A 068}	Continued From page 14 dizziness from her doctor's office. Patient #83 was seen by an ED MD #1 on arrival and at 1218 a comprehensive metabolic panel (CMP) [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 RN #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an inpatient bed. At 2329 Hospitalist MD #9 ordered	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 15 an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). On 11/29/2023 at 0127 MD #9 ordered a Lactic Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these, later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 cancelled the 0127 NOW Lactic Acid order "nurse collect" from the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes after ordered) with result of 12.3 (normal high	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 16 range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was in the lab for processing at 0907, and resulted at 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337. Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 17	{A 068}		

to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work.

Request to interview MD #9 revealed she was unavailable for interview.

Request to interview MD #16 revealed he was unavailable for interview.

Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed.

Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble getting in contact with the phlebotomist. That morning they were not logged into to their imobile device. I called the general lab number, and no

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 068}	Continued From page 18	{A 068}		

one answered. I then contacted my house supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I strongly advocated for her to get moved into a

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 19 bed with the CNC (clinical nurse coordinator), and it didn't happen. She didn't think it was a big deal. We don't have the capability to link the patient to a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83. Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83.	{A 068}		

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{A 068}	Continued From page 20	{A 068}		

Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.

3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol Withdrawal Plan, effective date 07/20/2022 revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 21 than) 15..." The CIWA/Alcohol Withdrawal Plan Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10.Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..." Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, ekg, and chest Xray were completed, and Patient #43 was assigned to ED Medical Doctor (MD) #23. Review of the ER Physician Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, ekg and chest Xray	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 068}	Continued From page 22 results from 08/14/2023 did not show any critical results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and a CIWA Scale reassessment was due to be completed per protocol. No nursing reassessments, medication administrations, IV	{A 068}		

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{A 068}	Continued From page 23 access/fluids, or physician orders were completed after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was documented before the patient had a seizure event with sustained head injury. There was no nursing reassessment, or nursing care after	{A 068}		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 24 08/14/2023 at 1851 by RN #22 until 08/15/2023 at 0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at 0334 from the ED. Patient #43 was discharged home on 08/17/2023. Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to sent out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload." Request to interview MD #23 revealed she declined the interview. Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be monitored ..." Interview revealed MD #26 had concerns for patient safety in the ED waiting room	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 25	{A 068}		

due to delays in patient monitoring.

Interview on 11/15/2023 at 1615 with NP #36 revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 26	{A 068}		

There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43.

Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43.

Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not been completed.

Patient #43, a 39-year-old who presented to the

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 27 emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency severity index (ESI) of 1-Resusicitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG, lab work, chest Xray and CT (cat scan) of the	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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{A 068}	Continued From page 28 head. At 1005 Haldol (given to treat severe behavior) 10 mg Intravenous was ordered by MD #59 and given due to combativeness. Review of the ER Note by MD #59 dated 07/05/2023 at 1002 revealed ".....history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now,... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed.. The Head CT was negative. Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 29 10 minutes...We have been running norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 30 "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040. Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding.	{A 068}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 31 Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient	{A 068}		

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{A 068}	Continued From page 32 #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of	{A 068}		

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{A 068}	Continued From page 33 levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation. Request to interview ED RN #68 revealed she was not available for interview. Request to interview ED RPH #78 revealed she was unavailable for interview. Request to interview ED Manager RN #75 revealed he was unavailable for interview. Request to interview ED Director, RN #76 revealed she was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 34 trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available for this surveyor). Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull resources..." Further interview with CNC RN #74	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 35 revealed "...she had no concerns with nursing reassessments in the ED... that nursing assignments in the Red Pod (where the most acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care. Interview on 11/15/2023 at 1637 with VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed. Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28.	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 36 Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him. Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient.	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 37 The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest. 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 38 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136. Request for a Patient Safety Report (Incident Report) revealed there was not one available. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room,	{A 068}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 39	{A 068}		

some changes were made, and there are some improvements. It's very possible that this patient waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022.

Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 40 Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management. 6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters. Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain medication, antibiotics, and lab work." PA #45 ordered	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 41 X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients) Hallway Bed 7. At 1517 Patient #29 was triaged by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2. 20g Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), RN #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5mg IV for a pain score of 10/10 and Zofran 4mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain reassessment was charted as 9/10 (no evidence of an oxygen reassessment). At 1748 the	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 42 Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open tibial shaft fracture..." with plan for surgery to repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (no evidence of this in the record). She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at 1909. Review of the Patient Event Record dated	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 43 04/06/2022 at 0341 by Nursing/Surgical Services #54 revealed the event was "unexpected death" date of event "04/05/2022 at 1903" with narrative "...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsive in hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to event per report. Request to interview Trauma Nurse, RN #56 revealed she was unavailable for interview. Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital policy for reassessment was not followed for Patient #29.	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 068}	Continued From page 44 Telephone interview on 11/16/2023 at 1324 with MD #46 revealed she did not recall Patient #29. Interview revealed "...monitoring of patients in hallway beds are a concern. Ideally every patient in the Red Pod should be on some sort of a monitor with a pulse oximeter. More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside. Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29. Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be placed on a cardiac monitor which showed asystole. At 1909 was the time of death pronounced with her daughter at the bedside.	{A 068}		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 45 Interview revealed this event was reviewed by the Mortality and Morbidity which was comprised of multiple providers and the MD who had completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.) Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing). 7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood thinners and 10 days post partum. What aspect	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 46 of reason for visit is concerning to patient? : Stroke symptoms......." Review of a MD "ER Report", service date/time 10/03/2023 at 1714, revealed " .... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the fact the patient is 10 days postpartum which does	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 47 place her at an elevated risk for ischemic CVA (stroke). Differential at this point would also include complex migraine, preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke. ..... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most urgent transport)......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no obvious distress....report is as follows: .....Dx	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 48 (Diagnosis): HTN (hypertension) crisis, Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and weakness and tingling onset....10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and leg weakness along with a facial droop and neck	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 49 pain. Vital signs continued approximately every 5 minutes, with the last recorded blood pressure 147/90 at 2215. Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H .....ED Full Triage Arrival Mode - ED (Emergent) : EMS .....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital....." Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form. ... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry neurologist decision was made against using tPA (breaks down blood clots). She was transferred here for further stroke eval and MRI (magnetic	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 50 resonance imaging). She was also notably hypertensive at outside hospital with blood pressure 160s systolic. She has also had some headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here. Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop Preeclampsia...... " Record review failed to reveal	{A 068}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 51 acceptance and monitoring of Patient #6 by nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023. Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring. Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds	{A 068}		

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{A 068}	Continued From page 52 available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible." Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia. Telephone interview with Patient #6's Triage Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation. Interview revealed the EMS team was	{A 068}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 53 responsible for any patient they brought in until the patient got a room assignment and was moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Telephone interview on 11/17/2023 at 1205 with MD #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 54 until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed "...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed "....History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)...... Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with neurologic symptoms concerning for acute ischemic stroke I think she will likely be a candidate for thrombolytics assuming that we can	{A 068}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 55 get her blood pressure down. She is going to CAT (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. .... " Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority. Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). ..... THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED ....THE PHYSICIAN ADVISED TARGET BLOOD	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 56 PRESSURE IS 140/90 AND ADVISED TO MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE..... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT .... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED ......" Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and hand-off to the hospital. Review of the Hospital A medical record for	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 57 Patient #1, on 11/14/2023, revealed the patient arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351, revealed "... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management....Physical Exam......Initial Vitals No Data Available ....Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making .... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ..." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated "...Impression and Plan:.....#ICH (Intracranial Hemorrhage): hypertensive etiology suspected .... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on one side of the body). Plan: admit to ICU for close neurologic monitoring. ..." Review of the ED record failed to reveal any vital signs or	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 58	{A 068}		

Continued From page 58

assessments by nursing. Review revealed "Nurse Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by (Name), RN. ED CNC (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85.

Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED.

Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients in the ED as soon as they were notified of the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 59	{A 068}		

patient's arrival. Interview revealed it was "surprising" not to have vital signs completed in the ED and stated it did not meet expectations for care - patients needed hourly neuro checks and vital signs with provider updates on changes.

Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN.

Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
{A 068}	Continued From page 60 was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE BIG TOE OF HIS LEFT FOOT. IT WAS NOW	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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{A 068}	Continued From page 61 NOTED THAT PT'S EKG WAS SHOWING ....ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY A&Ox4 PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN. ....." EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care ......"	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 068}	Continued From page 62 Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7. Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed "... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks. .. He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic, Diflucan (antifungal), and Duricef (antibiotic)....Medical Decision Making.... EMS reports that they gave patient 324 mg aspirin.... blood pressure was approximately 96 mmHg. They gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that patient had 7 beat run of V tach on their EKG	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 63 tracing in route with patient now in sinus rhythm and occasional bigeminy. Ordered EKG and for patient to be on telemetry. Point-of-care CBG (blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach....1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017.....Called lab to request results of chemistries be available as soon as possible. Labs resulted after arrest ... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack). Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 64 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm .....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For this patient who presented with chest pain,	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 65	{A 068}		

syncope, and suffered cardiac arrest has either suffered an MI or rhythm disturbance.....I reviewed his medications..... I made attempts to address .....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole .....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46
... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest. ..."

Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17 minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 068}	Continued From page 66 and it seemed like a staffing issue. Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the patient came into the ED with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival. Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient #2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in	{A 068}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 67 a room and care handed-off from EMS, interview revealed, they were "counting on EMS to care for (the patients). " Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol, but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. The hospital staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment. 10. Closed medical record review of Patient #12	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 068}	Continued From page 68 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival). Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 068}	Continued From page 69	{A 068}		

seen by providers and prescribed medications while "on the wall" but can not get them because no RN has been assigned.

11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention".

Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...".

Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 068}	Continued From page 70 documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	{A 068}		
{A 092}	EMERGENCY SERVICES CFR(s): 482.12(f)(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on policy review, medical record review,	{A 092}	**Subject of Deficiency: A 092** The hospital's leadership failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the emergency department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders. Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below. Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section (See Plan of Correction for A 1100)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 092}	Continued From page 71 incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, hospital leadership failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the emergency department, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 ED records reviewed (#92, #83, #43, #28, #27, #29, #6, #1, #2, #12 and #26). The findings included: Cross refer to all findings at §482.55: Emergency Services A 1100. Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). 1. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The	{A 092}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 092}	Continued From page 72 patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented. 2. Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic	{A 092}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 092}	Continued From page 73 acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023. 3. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed	{A 092}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 092}	Continued From page 74	{A 092}		

IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest.

5. Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired.

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 092}	Continued From page 75	{A 092}		

Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing).

7. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff.

8. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED.

9. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 092}	Continued From page 76 after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment. 10. Patient #26 presented to the ED via EMS on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022. 11. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. Record review revealed the patient did not have her vital signs monitored and had no nurse assigned to monitor status or provide care.	{A 092}	**Subject of Deficiency – A 115** The hospital staff failed to promote and protect patient's rights by failing to provide a safe environment to Emergency Department patients and failed to obtain consent to treat authorization for pediatric patients. **Subject of Deficiency: A 131** The hospital staff failed to promote and protect patient's rights by failing to obtain consent to treat authorization for pediatric patients. **Subject of Deficiency – A 115** The hospital failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) Pods (cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area. **Subject of Deficiency: A 144** The hospital failed to ensure a safe environment for behavioral health patients subject to self- harm in the Emergency Department (ED) Pods (cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area. Mission Hospital ED is a medical ED where care is provided to all patients, including those who may present with behavioral health complaints. The ED at Mission Hospital does not maintain a designated behavioral health area.	
{A 115}	PATIENT RIGHTS CFR(s): 482.13	{A 115}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

{A 115}

Continued From page 77

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:
Based on policy review, medical record review, Emergency Medical Services (EMS) trip report review, incident report review, observations, environmental risk assessment review and staff and provider interviews, the hospital staff failed to promote and protect patient's rights by failing to provide a safe environment to Emergency Department patients and failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions.

The findings included:

The hospital staff failed to ensure a safe environment for behavioral health patients subject to self-harm in the ED by failing to limit environmental risks in the Emergency Room pods (cluster of rooms in a designated area) used to house Behavioral Health patients awaiting placement (Green Pod and Purple Pod).

Cross refer to 482.13 Patient Rights' Standard: Tag A 0144.

The hospital nursing staff failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions for 1 of 4 sampled pediatric behavioral health patient records reviewed (Patient #75).

Cross refer to 482.13 Patient Rights' Standard: Tag A 0131.

{A 131} PATIENT RIGHTS: INFORMED CONSENT

{A 115}

Safe Environment Immediate Corrections and System Changes: A115 and A144

Immediate Actions Taken:

- 2/3/24 Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying additional ligature risk items such as the call cord as a potential ligature risk. — 2/3/24
- 2/3/24 Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern. — 2/3/24
- 12/14/23 Increased safety rounding conducted by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks. — 12/14/23

System Changes:

- 2/3/24 The necessity of objects in each room, as well as anything that is specifically located in the rooms, were evaluated and anything not required for direct patient care was removed following an ongoing ligature risk assessment. — 2/3/24
- Ongoing sustained process commenced in 2022 patients presenting to the emergency department with a behavioral health complaint are screened using the Columbia Suicide Severity and Risk screening process. Patients identified to be at risk will have appropriate risk mitigation strategies through implementation of interventions such as: in-person 1:1, camera observation, and/or q15 minute rounder.
- 2/3/24 Additional safety sweeps were conducted to identify and remove potential ligature risks/ unnecessary equipment or areas of safety concern — 2/3/24
- 2/3/24 Emergency department leadership, accreditation readiness specialist, and facilities conducted a new Ligature Risk Assessment to include each room in the emergency depart identifying new ligature risks items such — 2/3/24

{A 131}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 131}	Continued From page 78 CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on review of the "Authorization for Nonpsychotropic Medicinal Intervention" form, medical record review and interview, the nursing staff failed to obtain authorization for psychotropic and nonpsychotropic medicinal interventions for one (1) of four (4) sampled pediatric behavioral health patient record reviewed. (Patient #75). The findings included: Request for policy revealed the hospital staff advised there was no policy available. The hospital provided a consent form titled "Authorization for Nonpsychotropic Medicinal Intervention" which stated "By signing below I, as the Legally Responsible Person for the minor, _________, do hereby give my consent for the physician to perform medicinal intervention as related to the aforementioned minor. I understand that the physician will be using ________as medication for the purpose of treating the minor for ________. I also understand that I can revoke this consent at any time" and "Authorization for Psychotropic Medicinal Intervention" which stated	{A 131}	as the call cord as a potential ligature risk. • 2/6/24 Education provided to the emergency department staff (RN, PCT, Paramedic, Unit Clerk, ED Leadership) on what is a potential ligature risk to patients • Education provided to the Patient Safety Attendants (PSA) regarding what is a potential ligature risk to patients • 2/6/24 Increased safety rounding conducted by the administrative house supervisor, patient safety attendant lead, and nursing team lead to monitor real time compliance in ligature risks **Education Provided to Staff:** **2/6/24 ED Huddle start date 2/5/24** **PSA Huddle start date** • Emergency department shift huddles are conducted at the start of each employees working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to education 100% of working staff to potential ligature risks to patients. **Education conducted by Charge nurse and or Manager.** • Patient Safety Attendant education conducted in huddle at the start of each working shift. **Education conducted by PSA team lead to** capture 100% of working staff are educated to potential ligature risks to patients. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions. • Closed loop understanding of huddle information is tracked via staff signed document • Emergency Department education ligature risk education focused on topics regarding environmental safety, CSSRS, ED expectations, and closed loop communication. Re-circulated CSSRS huddle card which includes displayed icons for ED tracking board for overall care team awareness	2/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

{A 131}

Continued From page 79

"By signing below I, as the Legally Responsible Person for the minor, _________, do hereby give my consent for the physician to perform psychotropic medicinal intervention as related to the aforementioned minor. I understand that the physician will be using ________as medication for the purpose of treating the minor for ________. I also understand that I can revoke this consent at any time." The forms provided spaces for date/time, legally responsible person signature, relationship, and witness signatures.

Review on 12/04/2023 of the closed medical record for Patient #75 revealed a 12-year-old female that presented to the Emergency Department on 06/30/2023 at 2251 by law enforcement with Involuntary Commitment (IVC) paper for assault on therapist and mother. Patient #75 was admitted to inpatient behavioral health services on 07/01/2023 at 2027. Review of the Medication Administration Record (MAR) showed that Patient #75 was administered Zyprexa on 07/01/2023 at 0018, Melatonin and Trazodone at 0045, Prozac, Guanfacine, Lamictal and Quetiapine at 0817, Tylenol at 0913, Benadryl and Zyprexa at 1006 and Sarna Topical Lotion at 1035. Review of the medical record revealed a signed authorization/consent form dated 07/01/2023 at 1614 for the following psychotropic medicinal interventions: Zyprexa (15 hours and 56 minutes after administered), Trazodone (15 hours and 29 minutes after administered), Prozac, Guanfacine, Lamictal and Quetiapine (7 hours and 57 minutes after administered) Zyprexa (6 hours and 8 minutes after administration). Review of the MAR revealed that Patient #75 was administered Benadryl on 07/01/2023 at 1006 with no evidence of a signed authorization/consent form from the

{A 131}

Monitoring for Compliance/Audit Details:

Daily, in person, rounding observations to monitor, track, and ensure that the safety measures are implemented. Patient Safety Rounding audits are used to monitor compliance with ligature risk mitigating factors such as environmental safety and patient safety attendant awareness. Ensuring the POC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements.

1. Patient Safety Rounding audits are conducted by the administrative house supervisor, PSA team lead, or nursing team lead.

Sustained Compliance Audits to Ensure POC is Effective:

- The goal of our audit is to reach a minimum of 90% compliance with the rounding observations. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters. Numerator = # of compliant patient safety round observations
Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

2. Education: Daily monitoring and tracking using the huddle tactic to ensure 100% of working staff are educated to potential ligature risks to patients.

See above section Education Provided to staff bullet 1 and 2.

Owner: Chief Nursing Officer/ACNO/VP of Emergency Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 131}	Continued From page 80 parent/guardian. Review of the medical record revealed a signed authorization/consent form dated 07/01/2023 at 1614 for the following non-psychotropic medicinal interventions: Melatonin (15 hours and 29 minutes after administered), Tylenol (7 hours and 1 minute after administered), and Sarna Topical Lotion (5 hours and 39 minutes after administered). Interview on 12/06/2023 at 1520 with RN #84 revealed that consent forms should be obtained from the parent/legal guardian prior to administration of psychotropic and/or non-psychotropic medications to a minor.	{A 131}	**COA Immediate Corrections and System Changes: A115 and A131** • Began daily review on 2/6/24 to ensure all patients under the age of eighteen presenting to the emergency department have appropriate Consent of Admission (COA) completed. • New education created regarding Consent of Admission (COA) Procedures: Minors and Involuntary Commitment (IVC) to highlight identified areas of opportunity • New education Consent of Admission: Minors and Involuntary Commitment (IVC) added to general orientation and onboarding • New education provided to all patient access staff members working in the emergency department regarding COA **Education Provided to Staff:** **Date: 2.6.24** • Education regarding COA added to general orientation and onboarding • Patient Access education for staff working in the emergency department conducted via HealthStream and huddle during working shift. **Education conducted by Patient Access Team Lead, Manager, or PAS Leadership to** capture 100% of working staff are educated to Consent of Admission • Education in the daily huddle format for patient access staff working in the emergency department (huddles conducted at 12:45 and 10pm) is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions. **Monitoring for Compliance/Audit Details: Date: 2.6.24** Utilizing the electronic medical record, pediatric patients who present to the emergency department are reconciled and audited for completion of COA.	
{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 observations, review of the "Environmental Risk Assessment for Suicide Prevention" form, and staff and provider interviews, the hospital failed to ensure a safe environment for behavioral health patients subject to self-harm in the Emergency Department (ED) Pods (cluster of rooms in a designated area), and identify and/or remove potential environmental hazards that were located in the designated behavioral health area. The findings included: Observation on 11/13/2023 at 1150 during tour of	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE

{A 144}

Continued From page 81

the emergency department (ED) revealed Green Pod had twelve patient care rooms, eight of which had adolescent behavioral health patients in them. Three of the eight patients had a sitter at the doorway of their room (Room 78, 80, and 83). Observation revealed all eight behavioral health patients had a corded call bell. Tour of the Purple Pod revealed a twelve-patient care room unit with eleven behavioral health adult patients in them. Observation revealed all eleven patients had corded call bells. There were two sitters for two of the eleven patients (Room 44 and 48). There were three rooms in the Purple Pod that had Hoyer lifts (device to assist with moving and lifting a patient who cannot move themselves) on the ceiling (Rooms 37, 42, and 45). The twelve rooms and the bathrooms in the Purple Pod had rectangle shaped hook(s) behind the door that were not breakaway hooks. Staffing consisted of two Registered Nurses and a Rover (a Patient Safety Attendant assigned to round every fifteen minutes on the patients in the unit).

Observation on 11/15/2023 at 1315 in the Purple Pod revealed eight behavioral health adult patients. The Rover (Patient Safety Attendant assigned to perform every fifteen-minute checks) took a corded telephone into Room 46 and left the room. The patient in the room did not have a virtual sitter nor a one-to-one sitter while having the corded telephone.

Observation on 11/30/2023 at 0947 during tour revealed there were four patients in the Green Pod with corded call bells. There were no sitters with the four patients. The patient in room 77 had a hospital bed with a fitted sheet on the bed instead of the behavioral health safe sheets (linen that is designed to not hold tied knots).

{A 144}

- Daily monitoring of appropriate pediatric emergency department charts for completion of COA. This daily audit is being conducted currently to identify real time fallouts in our process.

Sustained Compliance Audits to Ensure POC is Effective:

We will conduct audits as outlined below to monitor our sustained compliance.

- The goal of our audit is to reach a minimum of 90% compliance with a completed COA. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
  Numerator = # of completed COA
  Denominator = 70 pediatric emergency department charts a month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Financial Officer/Director of Patient Access

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 144}	Continued From page 82 Observation revealed Rooms 73 and 82 had bathrooms within the patient rooms. Each bathroom contained safety handrails that you could tie something completely around the rail, normal toilets, regular faucets on the sinks, and regular mirrors. Observation during tour of the Purple Pod revealed the Pod had been "flipped" back for non-behavioral health patients. On 11/30/2023 a review of the "Environmental Risk Assessment for Suicide Prevention" performed on 09/08/2023 revealed any ligature risk identified were listed as being mitigated by monitoring needs that were put in place as identified by the suicide risk scores. Interview on 11/27/2023 at 1500 with Acting Chief Nursing Officer (ACNO) #47 revealed that all the rooms are ED rooms and all the Pods in the ED were used for any type of ED patients. A behavioral health patient could be placed anywhere in the ED not only in the Blue Pod, or the current overflow Pods, Green and Purple, that were currently used to house overflow behavioral health patients. ACNO #47 stated that all behavioral health patients get a C-SSRS (Columbia Suicide Severity Rating Scale-assessment tool used to evaluate a patient's suicidal ideation and behavior) score performed by a nurse. The C-SSRS score was used to determine if a patient was low, moderate, or high risk (a yes answer on key questions within the assessment would increase the score from low to moderate or high risk). Interview revealed a medical provider would perform their assessment and their determination trumps the score of the nurse. Interview revealed the risk of self-harm was mitigated based on the patients' C-SSRS score, if a patient was Low risk, they were	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 144}	Continued From page 83	{A 144}		

rounded on every fifteen minutes by the Rounder, if the patient was Moderate risk, they got a virtual sitter, and if the patient was High risk, they got a one-to-one sitter.

Interview on 11/27/2023 at 1504 with Nurse Vice President for ED Services #20 revealed the risk of self-harm were mitigated based on the patients' C-SSRS score. Interview revealed if a patient was Low risk, they were rounded on every fifteen minutes by the Rounder, if the patient was Moderate risk, they got a virtual sitter, and if the patient was High risk, they got a one-to-one sitter. The nurse would check on the patient as they deem appropriate and perform safety checks on every patient in the Pod every hour.

Interview on 11/28/2023 at 1306 with COO (Chief Operating Officer) #50 and ACNO #47 revealed nursing took safety steps for overflow areas of behavioral health patients in the Green and Purple Pods. The staff members reported that nursing checked off in the electronic medical record that they have validated the rooms were safe for the patient. The hospital saw an increase in the number of behavioral health patients, so when the new Pediatric ED area opened in September of 2023, the space that was previously used for pediatrics (identified as the Purple Pod) became an overflow/holding area for behavioral health patients. Interview revealed the last known time a medical ED patient was in the Purple Pod (a pediatric patient) was September 26, 2023 (after the environmental risk assessment for suicide prevention was performed on September 8, 2023). Interview revealed safety for behavioral health patients in the Green Pod based on their C-SSRS score would be every fifteen-minute check by the Rounder or the virtual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 144}	Continued From page 84 sitter, or the one-to-one sitter. Depending on the volume of patients and their acuity (high risk, elopement risk, patients that wander) there would be either one or two Rounders in the Pod. Interview revealed if the volume was low, the hospital may need to and can put an adult patient in the Green Pod with the adolescent behavioral health patients. Interview revealed that based on the C-SSRS score, they would put in place mitigators (staff to monitor) to assure safety for patients. The staff member stated they do not monitor and cannot pull the data to determine the last time there were both pediatric/adolescent and adult patients in the Green Pod at the same time. Interview revealed the staff do not monitor when the Pods are used as behavioral health only patients versus medical ED patients, nor how frequently they are being flipped back and forth. It was reported that the staff mitigate the risk of harm in the room space down to what is deemed appropriate by removing trash cans, suction, cords, and make sure the beds have a behavioral health approved sheet on it. Interview revealed the corded call bell was not removed from the room as it is the patient's way of calling staff if they need something and it operates the television in the room. Mitigating factors (every fifteen-minute check, virtual sitter, or one-to-one sitter) are put in place based on the C-SSRS score. The staff member reported corded telephones are used if the patient wants to make a telephone call, and that it was a patient's right to make telephone calls. If the patient was high risk, have a one-to-one sitter with them when they have the telephone, if they were a moderate risk they have a virtual sitter with them, and the low risk has an every fifteen-minute check done by the Rounder. The "nurses are really in tune with the patients" in behavioral health. Interview	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 144}	Continued From page 85 revealed the nurses rotate throughout the ED and were not always working in the pods that have behavioral health only patients in them. Interview revealed the Green Pod and Purple Pods were not psych friendly. Mitigating factors were put in place such as every fifteen-minute check, virtual sitters, or one-to-one sitters based off the patients C-SSRS score. Interview on 11/30/2023 at 1532 with Manager #51 and Manager #49, that performed the Suicide Risk Environmental Assessment on 09/08/2023, revealed the Green Pod and Purple Pod areas were a medical ED and not a Behavioral Health unit. Behavioral Health patients could be in any area of the ED. The staff reported that all risks for behavioral patients in the ED could be mitigated by every fifteen-minute observation, a virtual sitter, or a one-to-one sitter. The staff stated, the call bell cords break away from the wall if, for instance, someone pulled on it or put too much pressure on it. It was stated that they did not look at the cord itself as a risk used for hanging or self-harm, just that it could break away from the wall. Telephone cords were not evaluated on the risk assessment that was performed, and staff reported they were not aware that Behavioral Health patients were given a telephone with cords in their rooms. The interview revealed that a risk assessment was done for the entire ED on September 08, 2023. Interview revealed the staff conducting the assessment did not go in every room in the ED when they did the Environmental Risk Assessment for Suicidal Prevention. The staff members stated that they did not go back and look at the Purple Pod that was converted over to behavioral health holding/overflow after the pediatric patients were moved to the new pediatric ED.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{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 complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:
Based on policy review, Quality Performance Improvement Plan review, medical record review, incident report reviews, pharmacy unit inspection review, and staff interviews, hospital leadership failed to ensure adverse events were documented, tracked, trended, and analyzed in order to implement preventive actions and identify success of actions taken.

The findings included:

1. The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for seven (7) of 94 sampled patient records reviewed. (Patient #'s 58, 27, 59, 50, 15, 13, and 2).

{A 263}

Subject of Deficiency: A 263 Hospital leadership failed to ensure adverse events were documented, tracked, trended, and analyzed in order to implement preventive actions and identify success of actions taken.

Plan of Correction:

Actions:

- Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety.
- Daily report out of patient safety reports at Safety Huddle
- Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration
- Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports
- Quality/Patient Safety/Risk oversight of patient safety reports closure
- Routine patient safety reports report emailed to hospital leadership for review of reported events from past 24 hours
- Routine review of patient safety reports by Hospital Leadership and members of the Quality/Patient Safety/Risk team
    - Facilitation of early event identification for timely investigation/action as appropriate
    - Monitor for trends
    - Ensures routing of events to appropriate parties for review
        - Provider-related concerns and events escalated to service line leadership and/or peer review as appropriate
        - All mortality events captured in daily mortality report being reviewed by CMO/ACMO
- Intense Analysis/SEAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 263}	Continued From page 87 Cross refer to §482.21 Standard: QAPI Quality Improvement Activities: Tag A 0286. 2. The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action for 7 of 94 sampled patients reviewed. (Patient #'s 58, 27, 59, 50, 15, 13 and and 2). Cross refer to §482.21 Standard: QAPI Quality Improvement Activities: Tag A 0309.	{A 263}	o Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team as appropriate o Lessons learned and best practices shared via case studies at monthly Patient Safety Committee **Monitor for Compliance:** • Monthly reporting in Quality Council • Reporting through Board of Trustees (BOT) **Owner:** Chief Medical Officer/ACMO **Subject of Deficiency: A 286**	
{A 286}	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility	{A 286}	The hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action. **Plan of Correction:** **Education:** **12.3.23 Healthstream online annual safety event reporting mandatory education completed for all staff.** **Actions:** • Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety. • Daily reporting of patient safety reports activity at Safety Huddle • Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration • Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 286}	Continued From page 88	{A 286}		

Continued From page 88

for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...
(3) That clear expectations for safety are established.
This STANDARD is not met as evidenced by:
Based on policy review, medical record review, incident report review, pharmacy unit inspection review, personnel file review, hospital document review and staff and physician interviews, the hospital staff failed to ensure tracking and trending of medical errors by failing to document incidents for improvement opportunities and failing to investigate potential causes and identify corrective action for seven (7) of 94 sampled patients reviewed (Patient #'s 58, 27, 59, 50, 15, 13 and 2)

The findings included:

Review of the hospital policy titled "Event and Close Call Reporting" revised 10/13/2022 revealed "... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems ... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems... This policy applies to services provided by (Hospital Corporate Name) staff members in each of these settings: ... *Inpatient services, including acute care and behavioral health, critical access hospitals, and other related services * Emergency Departments (ED) * Hospital-based outpatient department or ambulatory services, including but not limited to behavioral health services and Independent Diagnostic Testing Facilities ... *Physician practices or clinics that may include rural health clinics or federally qualified health

- Quality/Patient Safety/Risk oversight of patient safety reports closure
- Routine patient safety reports emailed to hospital leadership for review of reported events from past 24 hours
- Routine review of patient safety reports by Hospital Leadership and members of the Quality/Patient Safety/Risk team
- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Provider-related concerns and events escalated to service line leadership and/or peer review as appropriate
- Ensure that any mortality events are also captured in daily mortality report being reviewed by CMO/ACMO
- Intense Analysis/SEAs
- Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team as appropriate
- Lessons learned and best practices shared via case studies at monthly Patient Safety Committee

Monitor for Compliance:
- Monthly reporting via Patient Safety Committee
- Monthly reporting via Quality Council
- Reporting through Board of Trustees (BOT)

Owner: Chief Medical Officer/ACMO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 286}	Continued From page 89 care centers ... NC Division Clarification ... In addition to the roles listed in the policy, the Directors of Quality and Patient Safety and/or Administrative Quality Directors are also responsible for oversight of this process ... Escalation to Leadership ..." 1. Medical record review revealed Patient #58 had a witnessed fall on 04/26/2023 following abdominal surgery for a gun shot wound. A CT (cat scan) of the Abdomen and Liver on 04/26/2023 showed changes to a liver hematoma (clotted blood within the tissues) from the previous CT study on 04/25/2023. Patient #58 was moved to ICU (intensive care unit) for closer monitoring, and Interventional Radiology was consulted to rule out active bleeding. On 04/27/2023 Patient #58's hemoglobin dropped from 13.2 to 7.3 [6.0] and he received 2 units of red blood cells, and he underwent CT Angiogram and found no active bleed. Request for an event report on 12/05/2023 revealed there was not one available for Patient #58 after a witnessed fall, that required interventions. Telephone interview on 12/06/2023 at 1332 with RN #95 revealed she remembered the patient. Interview revealed "...he said he was going to pass out. We assisted him back to the bed after the fall and called a rapid response. I called the doctor. I didn't remember to complete a report, it was not quite a fall. I guided him to the bed, and another nurse picked his legs up onto the bed..." Interview revealed Patient #58 had a witnessed fall, and an event report was not completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58.	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 286}	Continued From page 90 Interview on 12/06/2023 at 1409 with the Charge Nurse, RN #96 revealed "...if a patient falls, we complete a (named) an incident report..." Interview revealed for witnessed falls an incident report should be completed. Interview revealed an event report should have been completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Telephone interview on 12/07/2023 at 0906 with MD #94 revealed he remembered the patient. Interview revealed "...he had a traumatic liver injury it would not be surprising to have a re-bleed, it required packing, and hemorrhage control. He did get an CT and have an interventional radiology angiography procedure after the event to ensure he didn't have an active bleed...It's impossible to tell...the fall did not extend an injury or stay at the hospital..." Interview revealed Patient #58 did have interventions after the fall on 04/26/2023 to ensure he had no active bleeding. Interview revealed hospital policy was not followed for event reporting for Patient #58 after a witnessed fall. 2. Review on 12/05/2023 of the policy Facility Event and Close Call Reporting Policy and Procedure, with effective date 04/01/2022 revealed "...PURPOSE: This policy is intended to minimize risks to patients, ...through the development and implementation of an event and close call reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report events and close calls to the Patient Safety Director, Risk Manager, or designee. Furthermore, this policy is intended to	{A 286}		

(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) COMPLETION DATE
{A 286}	Continued From page 91	{A 286}		

mitigate risks and improve quality of services by outlining the processes for factual reporting of events, close calls, and unsafe situations. POLICY: Facility staff will provide the needed data elements through a formal, documented event reporting system. Event reports should be completed as soon as possible after the event, but no later than the end of the shift...X. Fair and Accountable Reporting Culture...B. The responsibility for reporting an event or close call rests with any person who witnesses, discovers, or has direct knowledge of that event or close call..."

Medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported abdominal pain level of 10 of 10, and nausea and vomiting. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was not medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay in pain management, STAT lab work, STAT CT, and physician orders as prescribed.

Request for a Patient Safety Report (Event Report) revealed there was not one available.

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed patients had delays in receiving pain management, STAT lab work and completion of physician orders in the ED waiting room. Interview revealed an event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}		{A 286}		

Continued From page 92
report was not completed for Patient #27.

Interview on 11/17/2023 at 1102 with NP #39 revealed she had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview revealed an incident report should have been completed for Patient #27.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to place orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not receive pain management, STAT lab work, STAT CT, and physician orders as prescribed. Interview revealed an incident report should have been completed for Patient #27.

3. Closed medical record review revealed on 3/4/2023, Patient #59 was admitted to the oncology unit and received a diagnosis of acute myeloid leukemia. Per physician orders, treatment for acute myeloid leukemia included Dacogen (intravenous chemotherapy medication) and Venetoclax (oral oncology medication). On 3/17/2023, the patient was infused Dacogen after two (2) [oncology nurses] verified the medication. Further review revealed on 3/18/2023, an Oncologist documented that the patient received an expired dose of Dacogen.

The incident report for Patient #59's medication administration of the expired dose of Dacogen,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 93	{A 286}		

was requested on 12/7/2023 at 11:00 AM from the Director of Quality. No incident report was provided.

Upon inquiry for pharmacy unit inspections from March 2023 through November 2023 revealed there had only been one inspection documented on 5/16/2023.

Interview on 12/6/2023 at approximately 8:45 AM with the oncology pharmacist revealed oncology patients could be located on any unit within the hospital, in which case, the oncology medication would be delivered from outpatient infusion pharmacy to the oncology unit. The oncology nurse(s) would be responsible for going to the perspective unit(s) for the administration (intravenous and/or oral) of the medication. The pharmacist was unaware that an oncology patient was administered an expired dose of Dacogen.

Interview on 12/7/2023 at approximately 10:30 AM with oncology staff revealed that Patient #59 declined the first dose of Dacogen, which could have resulted in the administration of an expired medication.

Interview on 12/7/2023 at 11:00 AM with the Director of Quality revealed the Oncologist failed to enter an incident report and/or failed to speak to anyone regarding the administration of an expired dose of Dacogen to Patient #59 that occurred 3/17/2023.

Interview on 12/7/2023 at 1:51 PM with the Oncology Unit Manager (OUM) revealed in April 2023 the oncology unit adopted a more detailed treatment administration checklist to assist the oncology nurses and the pharmacy department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 94	{A 286}		

The OUM further indicated she could not speak to the effectiveness of the updated checklist because no audits had been performed.

Telephone interview on 12/8/2023 at 3:00 PM with the Oncologist revealed providers were made aware after-the-fact of any problems or concerns. As related to the administration of expired medication to a patient, the oncologist revealed, efficacy should be the main concern which falls upon the pharmacy department and was pretty sure this was what happened in the case of Patient #59. Further inquiry revealed that since the hospital joined [name of organization], the oncology unit lost valuable nurses which led to the hiring of new/inexperienced staff, and increased use of travel staff. The changes in staff led to an increase in errors, especially with neutropenic patients, which resulted in a degradation in care. Additionally, in the past oncology patients were directly admitted to the oncology unit without emergency department presentation. Now, oncology patients were admitted through the emergency department secondary to closure of transfers, which put the oncology patients at an increased risk for infection. Additionally, the unit no longer admitted complex cases of oncology patients because those cases were referred to other hospitals. Further interview revealed pharmacy errors increased secondary to the loss of experienced oncologist pharmacists. The interview concluded with the aforementioned concerns were voiced to the Medical Director for the oncology service line in which there were no notifications or any observations of changes.

4. Review of the closed medical record for Patient #50 revealed a 21-year-old female presented to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 95 the Emergency Department (ED) via law enforcement under IVC (involuntary commitment) for a "Psychiatric screening exam; Behavioral health concern." Review of the Provider Note dated 05/04/2023 at 1640 revealed "... patient presents with IVC paperwork and recent behavior concerning for danger to others in particular ... I will have behavioral health services see the patient ..." Review of the Initial Psychiatric Evaluation dated 05/06/2023 at 0531 revealed "The patient is a 21 yo (year old) female with h/o (history of) autism and mild intellectual disability, who was brought to the ED under IVC due to increasingly aggressive behavior. The IVC paperwork reports (sic) that the patient has been going around the neighborhood with a hammer. She has done thoughtless things such as covering her father's eyes with his hat while driving and then kicking him. The (sic) patient's behavior has been escalating since she could no longer participate in her programs during COVID 19 (pandemic). Instead of going to a group home, she was d/c (discharged) home from her last program. She has been increasingly irritable since she is swinging to calm herself down and has demonstarted (sic) dangerous behaviors ... Nursing reports pt (patient) became unexpectedly agitated this AM (morning), pulled nurse and sitter's hair after being asked if her ears hurt (she was pulling at them). She received 5 mg (milligrams) Versed (medication to help you relax) at time of arrival to the ED yesteay (sic) afternoon, but otherwise no PRN (as needed) medication. She has not required restraint ... She is mostly mute (refraining from speech), although sometimes echolalic (repeat others) and echopraxic (involuntary copying of another person's actions or movements). She waves when I wave. Says 'hello' when I say hello, and	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 96 'happy' when I ask if she is happy'(sic) ... Suggested plan; Uphold the IVC for now; observe the patient for the next 24-48 hours (sic); if the patient is stabilized, she can be discharged home or to a new placement, if one is available." Review of the Mental Health Contact Note dated 05/08/2023 at 1017 revealed "... reached out to Pt's mother, ..., and informed her that Pt was seen by Psychiatrist who is recommending discharge due to concerns of Pt safety on this unit, her aggressive behaviors w/ (with) other Pt's ..." Review of the Nurse Note dated 05/29/2023 at 0855 revealed "... This was the third time pt had attacked the hair of a sitter." Review of the Provider Note dated 05/29/2023 at 1007 revealed "...Patient was triggered by her sitter and attacked her this morning jumping on top of her and grabbing her hair ... Nursing staff reports this is the third sitter she is intact (sic) in the past 2 days ..." Review of the Nurse Note dated 06/10/2023 at 1920 revealed "Earlier today ... had multiple aggressive acts towards me, the first was when she spit on me as I was handing her a snack in the BHU (behavioral health unit) ... The second aggressive act came hours later when she saw me in the hall and came towards me. I attempted to walk away but she ran towards me, screaming and reaching for my face. She was able to pull the mask off my face but I restrained her hands and took several steps back, when she came after me again screaming and tearing at my head and face. I restrained her hands again and walked her back into her room towards her bed. As I let go and backed up ... leaned on her bed and kicked me in the chest with all her force ... I don't intend to escalate this matter any further and have explained the entire situation to the psych clinician." Mental Health Contact Note dated 06/18/2023 at 2100 revealed "... sitting in	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE

{A 286} Continued From page 97 {A 286}

BHU intake office and heard yelling. Pt seen ... on camera gripping a male pt hair in ... hallway bed. Pt was standing over male pt's hallbed (sic), hand in male pt's hair shaking pt's head around. Male pt was yelling ... immediately came out of BHU intake office, pt ran back towards her room into her bed. Male pt was visibly upset and yelling at pt in her room ..." Nurse Note dated 06/18/2023 at 2130 revealed "Pt. ran out of her room and pulled hair/hit another pt who was in a hall bed. After getting loose the pt. ran after her back in to her room, a BERT (behavioral health emergency) was called, physician, RNs, psych clinicians, and security all responded. The pt who was attacked aggressively was shouting, punching the walls, and hitting her bed. We were able to de-escalate the situation and both pts. We moved the second pt. to a differed pod in his own room so he would feel safe. It is unsure if (Patient #50) was hit while he was hitting her bed, physician did an assessment and she has no obvious injuries or marks. Pts are both settled in separate areas now." Review of the medical record revealed Patient #50 was discharged to a facility on 06/20/2023 at 1659.

Review on 12/05/2023 of the incident/variance reports provided regarding Patient #50 revealed there were no incident/variance reports for the incident on 05/29/2023 nor on 06/10/2023 to correspond with the incidents described in the medical record notes. There were incidents dated 05/27/2023 and 06/18/2023.

Telephone interview on 12/06/2023 at 1400 with PSA #48 revealed she remembered Patient #50 and had to push her distress alarm button when caring for Patient #50. Interview revealed there had been several incidents involving Patient #50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 98	{A 286}		

pulling staff hair, attacking staff or other patients. Interview revealed PSA #18 had submitted incident/variance reports herself regarding more than one incident with Patient #50. Interview revealed there was a male patient in her room one time. PSA #18 could not remember the details about this incident, however confirmed she had filled out an incident report. PSA #18 stated there was a time when Patient #50 kissed another patient and an incident report should have been filled out about that.

Interview on 12/06/2023 at 1500 with Director #82 revealed she only had four incidents/variances for Patient #50. Three of the four were dated 2022 and only one from 2023. Director #82 did not have the incident/variance provided to this surveyor dated 05/27/2023. Interview revealed the person entering the incident/variance did not enter the medical record number and Director #20 searched by the medical record number. Interview revealed it is hard to find incidents/variances if the medical record number is not entered so the information will pull across the system and make it easier to find. Interview revealed they can search by name however if the name is misspelled there would be problems finding any incidents/variances that were entered. Director #82 requested more time to research to see if there were more incidents/variances. At time of exit from facility on 12/09/2023 at 1600, Director #82 had not provided any additional information to this surveyor regarding additional incidents/variances for Patient #50.

5. Closed medical record review of Patient #15 revealed a 21 year old male admitted on 08/14/2023 with abdominal pain. Record review revealed the patient had laparoscopic converted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 99	{A 286}		

to open total abdominal colectomy (remove all or part of colon) with end ileostomy (stoma-opening in abdomen surgically created) on 08/27/2023 for ulcerative colitis. Record review revealed on 08/27/2023 at 1117 a ketamine drip was ordered stat (urgent). Record review revealed the patient arrived in PACU (post anesthesia care unit) at 1120. Patient transferred to floor (unit) at 1420. Record review revealed ketamine was started at 1448 on the unit. Patient returned to PACU at 1515 for ketamine drip. Review of nursing note on 08/27/2023 at 1526 revealed "Ketamine gtt (drip) sent to floor from pharmacy rather than to PACU. Patient arrived on the unit from PACU without ketamine gtt started. Notified (named) CNC (clinical nurse coordinator) and called to PACU nurse for patient to be transferred back to PACU for ketamine gtt initiation and required monitoring." Review of nursing note on 08/27/2023 at 1656 revealed "Pt (patient) transferred to floor after report called to RN (registered nurse). PT was ordered Ketamine and the pharmacy sent the medication to the nursing unit instead of PACU. RN agreed in report to start ketamine on pt arrival to floor, since the ketamine was on the unit. Pt later brought back to pacu when nurse became aware that she was not cleared by hospital regulations to start the ketamine gtt."

Review of a ketamine drip timeline document revealed Ketamine drip ordered at 1117. The order was verified by pharmacy at 1140, but the label was not printed. Missing medication request sent by the RN at 1228, high priority with comment "please bring to PACU pod 2 bay 9". Medication request was accepted by pharmacy at 1243 and label was printed. Label stated A3W/A336 as location. Medication hand delivered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 100	{A 286}		

to staff and signed as received by the named RN. Ketamine drip documented as initiated at 1448. Review of ketamine delivery signature sheet revealed no time of acceptance documented.

Review of the incident/variance reports provided regarding Patient #15 revealed there were no incident/variance reports for the incident on 08/27/2023 to correspond with the incident described in the medical record notes.

Interview on 11/16/2023 at 1045 with RPH #87 revealed medications are sent to locations based on the patient's location in the medical record. Interview revealed when patients are in PACU the pharmacy staff rely on nursing to put in a missing medication request in order to get the drug to the correct location.

Interview on 11/16/2023 at 1230 with PA #90 who ordered the drip revealed the drip was supposed to be initiated as soon as possible. Interview revealed the ketamine drip should have been started before the patient went to the floor. Interview revealed "the periop phase can be tricky and the patient's location does not populate automatically."

Interview on 11/16/2023 at 1421 with RN #88 revealed the PACU staff had waited for hours for the pharmacy to fill the order. Interview revealed the medication had been delivered to the floor and not to PACU. Interview revealed pharmacy was called several times to inquire about medication, "so we thought they knew that the patient was in PACU since we kept calling."

Interview on 11/17/2023 with NM #89 revealed ketamine drips are not done on the unit, they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 101 should be initiated on a higher level of care unit. Interview revealed the unit and pharmacy staff received education on which units can not initiate the ketamine drip. Interview revealed the education was in 12/2022. Interview revealed more education would be given to staff. Interview on 11/27/2023 at 1540 with RPH #79 revealed the nursing staff would put in a medication request when they are ready for the medication to be prepared. The RN has to put in the location of the patient with the medication request. Interview revealed the pharmacy staff that processed the label may not be the same staff member that delivered the order, and the patient's location may not have been communicated to the delivery technician. Interview revealed the delivery technician would then go by the location that was printed on the label. Request to interview a floor nurse revealed not available for interview. Request to interview the unit CNC revealed not available for interview. 6. Review of a policy titled "Physiologic Monitoring-Cardiac Telemetry Monitoring..." with a revision date of 08/14/2023, revealed "Internal (lateral) transfers within the (named hospital). C. Patients transferring to non-ICU (Intensive care unit) units with continuous ECG (Electrocardiogram) orders will transport on continuous ECG. 2. The receiving RN will notify CMU (cardiac monitoring unit) with patient name/MRN (medical record number), room being transferred to and telemetry box being assigned."	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 286}	Continued From page 102 Closed medical review on of Patient #13 revealed a 76 year old male admitted on 08/19/2023 at 1430 for hypertension (high blood pressure) and Intracranial hemorrhage (brain bleed). Review of RN #53's note written on 08/25/2023 at 1750 revealed "Transferred to Floor. Transfer Report Given to (RN #54). Transport equipment: Monitor. Mode: Wheelchair." On 08/25/2023 at 1934, Patient #13 was transferred to a stepdown unit. Review on 11/15/2023 of an incident report written by CMU supervisor #52 revealed (Patient #13)" had active 48 hr (hour) tele (telemetry) orders from 08.24.2023 at 1348 but were (sic) not being monitored." Review of telemetry strips failed to reveal a telemetry strip for evening hours of 08/25/2023. Review revealed Patient #13 was not monitored by telemetry for 6 hours. Review of a Safety Event Timeline dated 08/29/2023 at 1408 from Manager #56 from Floor A revealed "Status: Assigned to Manager #55, Manager of Floor B (sending floor manager)." Review revealed on "08/31/2023 at 1234, Status: Assigned. Closed." Review revealed no further documentation from Manager #55. Review revealed no documentation of the investigation of the Patient #13 without telemetry monitoring. Interview on 11/15/2023 at 1605 with CMU supervisor #52 revealed a daily audit is conducted at 0100 and 1300 of telemetry patients to ensure patients are being monitored as ordered. Interview revealed Patient #13 was found to have an order for telemetry but was not being monitored. Patient #13 had not been monitored since transfer to another floor on 08/25/2023 at 1934. Interview revealed Patient #13 was placed on telemetry on 08/26/2023 at 0139, 6 hours and 5 minutes after transfer to the	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 103 floor. Interview on 11/28/2023 at 1234 of RN #54 revealed no recollection of Patient #13 or details of the transfer. Interview revealed RN #54 had not been interviewed regarding the incident of Patient #13. Interview on 11/28/2023 at 1633 of RN #53 revealed no recollection of Patient #13 or details of the transfer. Interview on 11/30/2023 at 1645 with Risk Manager #58 revealed "incidents should be reviewed and escalated to the department leaders. There should be notes from the manager." Interview of Manager #55 was not obtained due to no longer employed. Patient #13 was transferred to Floor B with telemetry orders. After 6 hours, Patient #13 was discovered without telemetry. There was no review of the incident from the management of the sending floor or risk management. 7. Medical record review on 11/14/2023 of Patient #2 revealed the patient arrived to the Emergency Department on 10/17/2023. Review of the EMS Patient Care Record revealed EMS received a call at 1654, arrived to Patient #2's home at 1720 and transported the patient to the hospital, arriving at 1748. EMS documented they transferred care of the patient to the hospital at 1907, 1 hour 19 minutes later. Prior to the transfer of care, review revealed EMS continued monitoring Patient #2. A note in the EMS record indicated "Turn Around Delays.....ED	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 104	{A 286}		

Overcrowding/ Transfer of Care......"

The hospital ED record review revealed the patient arrived at 1753 via EMS, with complaints of chest pain, shortness of breath, and syncope. Patient #2 was noted as evaluated by a provider at 1845 (52 minutes after arrival) and triaged by a RN at 1900 (1 hour, 7 minutes after arrival). An EKG was completed at 1905 (1 hour 12 minutes after arrival) and labs, including troponin, were drawn at 1920 (1 hour 27 minutes after arrival). Record review revealed a delay in the hospital accepting the patient from EMS, triaging and initiating care to the patient, including an EKG and labs. Patient #2 went into cardiac arrest at 1953 (2 hours after arrival) and subsequently expired after failed resuscitation attempts.

Review of a document received from the hospital related to this patient, on 11/16/2023, revealed it was not dated or timed and was not signed. Document review revealed the following statement: "I have reviewed this case and the initial presentation, the timing on the workup, the findings and escalation were all appropriate and met standard of care. The patient arrived at 1753, was roomed at 1830 and was seen by a clinician at 1845 the patient coded at 19:53 and had a time of death at 22024 (sic) all of which occurred while in a room. The EKG was reviewed by the initial clinician and reported in the chart. The patient coded at 1953 and Dr. (Name) was called to the Code. During the code Dr. (Name) has documented that the patient had brief return of consciousness with the ongoing CPR. During this time he began reviewing the workup and the EKG, which was handed to him at 2002. It was read as sinus rhythm with a PVC and a 4 beat run of non-sustained ventricular tachycardia. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 286}	Continued From page 105 signed this EKG at this time 2002, the code was continued for another 22 minutes before time of death." There were no other notations on the received document including no identification of who completed it or when. The document did not identify any areas of concern. There was no documented review of the timing of triage or implementation of orders. Additional information on the document was requested on 11/17/2023. No updated information was received. Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed EMS was able to given hand-off report to a nurse at 1907 (over an hour after arrival). Interview revealed wait times for EMS to hand-off patients had recently gotten more common. Telephone interview with RN #66, on 11/16/2023 at 0938, revealed that until patients were in a room and care handed-off from EMS, they were "counting on EMS to care for (the patients). ...." Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the goal for screening evaluations was 20 minutes from arrival. Telephone interview on 11/16/2023 at 1100 with MD #72 revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. MD #72 acknowledged a delay with Patient #2. Interview revealed the physician was not aware if there was a review of the case. Review of documents received did not reveal an incident report. Review of findings and document provided revealed the hospital failed to identify and evaluate delays in accepting, triaging and	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE

{A 286} Continued From page 106
initiating care and treatment for a patient presenting via EMS with chest pain.

{A 309} QAPI EXECUTIVE RESPONSIBILITIES
CFR(s): 482.21(e)(1), (e)(2), (e)(5)

The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:

1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained .
(2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.
(5) That the determination of the number of distinct improvement projects is conducted annually.

This STANDARD is not met as evidenced by:
Based on policy review, Quality Improvement Performance Plan review, medical record review, incident report review, pharmacy unit inspection review, personnel file review, hospital document review and staff and physician interviews, the hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to

{A 286}

{A 309}

Subject of Deficiency: A 309

The hospital's leadership failed to provide oversight and responsibility of the quality improvement program to ensure medical errors were tracked and trended, failed to document incidents for improvement opportunities and failed to investigate potential causes and identify corrective action.

Plan of Correction:

Actions:

- Widespread dissemination of the importance of reporting any patient/staff/visitor events, near misses, and/or concerns for safety.
- Daily reporting of patient safety reports activity at Safety Huddle
- Unit/departmental leadership accountability for event investigation and actions, including referral for intradisciplinary/interdepartmental collaboration
- Routine call with ED leadership and Quality/Patient Safety/Risk for review of ED patient safety reports events
- Quality/Patient Safety/Risk oversight of patient safety reports event closure
- Routine patient safety reports report emailed to hospital leadership for review of reported events from past 24 hours
- Routine review of patient safety reports by Hospital Leadership and members of the Quality/Patient Safety/Risk team
    - Facilitation of early event identification for timely investigation/action as appropriate
    - Monitor for trends ensures routing of events to appropriate parties for review Provider-related concerns and events escalated to
        - service line leadership and/or peer review as appropriate
        - Ensure that any mortality events are also captured in daily mortality report being reviewed by CMO/ACMO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}	Continued From page 107 investigate potential causes and identify corrective action for seven (7) of 94 sampled patients reviewed (Patient#'s 58, 27, 59, 50, 15, 13 and 2). The findings included: Review of the Quality Improvement Plan approved by the hospital Chief Executive Officer (CEO), Board of Trustees Chair and Chief Medical Officer (CMO) on 04/24/2023 revealed, " ...The hospital-wide Performance Improvement Plan is designed to improve quality performance and patient safety, ultimately reducing the risk to patients. ... ACCOUNTABILITY ... The following individual and/or committees are accountable for setting expectations, developing plans, and implementing procedures to assess, improve quality, and measure performance improvement within the organization. ... Board of Trustees ... The Board of Trustees delegates the responsibility for implementing this plan to the Medical Staff, through its Medical Staff committees and the hospital through its Quality, patient safety, and Performance Improvement Committees and leadership team. ..... The (hospital name) Quality Council was organized as an interdisciplinary team with representation of Department Directors/Managers, hospital leadership, and key staff members with input from the Chief Medical Officer. The functions of the committee include but are not limited to: ......2. Review data including continuous measurement activities of important functions. 3. Identify of (sic) problems/opportunities for improvement. 4. Review of actions planned or completed. 5. Evaluate of (sic) the effectiveness of actions completed.......Staff will be accountable to: 1. Detect adverse events and near-misses. 2.	{A 309}	• Intense Analysis/SEAs o Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team o Lessons learned and best practices shared via case studies at monthly Patient Safety Committee **Monitoring:** • Monthly report out via Quality Council • Reporting through Board of Trustees (BOT) **Owner:** Chief Medical Officer/ACMO	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}	Continued From page 108	{A 309}		

Report events or near-misses via the incident reporting system. 3. Comply with all policies and procedures to mitigate risk and loss to the facility. ... Aggregation and analysis of performance data is used to compare internal performance with industry standards, comparable organizations, and best practices. ......Data is collected in a systemic manner to: a Establish a performance baseline and compare to national benchmarks ... d) Identify areas of opportunity for more focused data abstraction/reviews ..... Data analysis is performed to identify processes to be targeted for change or improvement. The intent is to reduce the probability of adverse outcomes and eliminate patient harm events. The following events or outcomes require data analysis:...... b) Performance measurements that reveal significant undesirable variation from recognized standards..... h) Patterns of frequent event reporting (i.e. patient injury, including near misses)...... Patient Safety/ Risk Management is responsible for ensuring a culture of safety while promoting safe, error-free care, and a safe environment for our patients, staff and visitors. Patient Safety/ Risk Management works collaboratively with hospital personnel as they review and triage all reported events and create detailed analysis of the causes of events...... "

Review of the hospital policy titled "Event and Close Call Reporting" revised 10/13/2022 revealed ". .. Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems ... Facility risk management personnel have the affirmative duty to oversee timely and thorough reporting within the designated systems. This policy applies to services provided by (Hospital Corporate Name) staff members in each of these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 309}	Continued From page 109	{A 309}		

settings: ... *Inpatient services, including acute care and behavioral health, critical access hospitals, and other related services * Emergency Departments (ED) * Hospital-based outpatient department or ambulatory services, including but not limited to behavioral health services and Independent Diagnostic Testing Facilities ... *Physician practices or clinics that may include rural health clinics or federally qualified health care centers ... NC Division Clarification ... In addition to the roles listed in the policy, the Directors of Quality and Patient Safety and/or Administrative Quality Directors are also responsible for oversight of this process ... Escalation to Leadership ..."

1. Medical record review revealed Patient #58 had a witnessed fall on 04/26/2023 following abdominal surgery for a gun shot wound. A CT (cat scan) of the Abdomen and Liver on 04/26/2023 showed changes to a liver hematoma (clotted blood within the tissues) from the previous CT study on 04/25/2023. Patient #58 was moved to ICU (intensive care unit) for closer monitoring, and Interventional Radiology was consulted to rule out active bleeding. On 04/27/2023 Patient #58's hemoglobin dropped from 13.2 to 7.3 [6.0] and he received 2 units of red blood cells, and he underwent CT Angiogram and found no active bleed.

Request for an event report on 12/05/2023 revealed there was not one available for Patient #58 after a witnessed fall, that required interventions.

Telephone interview on 12/06/2023 at 1332 with RN #95 revealed she remembered the patient. Interview revealed "...he said he was going to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}	Continued From page 110 pass out. We assisted him back to the bed after the fall and called a rapid response. I called the doctor. I didn't remember to complete a report, it was not quite a fall. I guided him to the bed, and another nurse picked his legs up onto the bed..." Interview revealed Patient #58 had a witnessed fall, and an event report was not completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Interview on 12/06/2023 at 1409 with the Charge Nurse, RN #96 revealed "...if a patient falls, we complete a (named) an incident report..." Interview revealed for witnessed falls an incident report should be completed. Interview revealed an event report should have been completed for Patient #58. Interview revealed hospital policy was not followed for Patient #58. Telephone interview on 12/07/2023 at 0906 with MD #94 revealed he remembered the patient. Interview revealed "...he had a traumatic liver injury it would not be surprising to have a rebleed, it required packing, and hemorrhage control. He did get an CT and have an interventional radiology angiography procedure after the event to ensure he didn't have an active bleed...It's impossible to tell...the fall did not extend an injury or stay at the hospital..." Interview revealed Patient #58 did have interventions after the fall on 04/26/2023 to ensure he had no active bleeding. Interview revealed hospital policy was not followed for event reporting for Patient #58 after a witnessed fall. 2. Review on 12/05/2023 of the policy Facility Event and Close Call Reporting Policy and Procedure, with effective date 04/01/2022 revealed "...PURPOSE: This policy is intended to	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 309}	Continued From page 111 minimize risks to patients, ...through the development and implementation of an event and close call reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report events and close calls to the Patient Safety Director, Risk Manager, or designee. Furthermore, this policy is intended to mitigate risks and improve quality of services by outlining the processes for factual reporting of events, close calls, and unsafe situations. POLICY: Facility staff will provide the needed data elements through a formal, documented event reporting system. Event reports should be completed as soon as possible after the event, but no later than the end of the shift...X. Fair and Accountable Reporting Culture...B. The responsibility for reporting an event or close call rests with any person who witnesses, discovers, or has direct knowledge of that event or close call..." Medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported abdominal pain level of 10 of 10, and nausea and vomiting. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was not medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay in pain management, STAT lab work, STAT CT, and physician orders as prescribed.	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}		{A 309}		

Continued From page 112

Request for a Patient Safety Report (Event Report) revealed there was not one available.

Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed patients had delays in receiving pain management, STAT lab work and completion of physician orders in the ED waiting room. Interview revealed an event report was not completed for Patient #27.

Interview on 11/17/2023 at 1102 with NP #39 revealed she had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview revealed an incident report should have been completed for Patient #27.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to place orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not receive pain management, STAT lab work, STAT CT, and physician orders as prescribed. Interview revealed an incident report should have been completed for Patient #27.

3. Closed medical record review revealed on 3/4/2023, Patient #59 was admitted to the oncology unit and received a diagnosis of acute myeloid leukemia. Per physician orders, treatment for acute myeloid leukemia included Dacogen (intravenous chemotherapy medication) and Venetoclax (oral oncology medication). On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 309}	Continued From page 113	{A 309}		

3/17/2023, the patient was infused Dacogen after two (2) [oncology nurses] verified the medication. Further review revealed on 3/18/2023, an Oncologist documented that the patient received an expired dose of Dacogen.

The incident report for Patient #59's medication administration of the expired dose of Dacogen, was requested on 12/7/2023 at 11:00 AM from the Director of Quality. No incident report was provided.

Upon inquiry for pharmacy unit inspections from March 2023 through November 2023 revealed there had only been one inspection documented on 5/16/2023.

Interview on 12/6/2023 at approximately 8:45 AM with the oncology pharmacist revealed oncology patients could be located on any unit within the hospital, in which case, the oncology medication would be delivered from outpatient infusion pharmacy to the oncology unit. The oncology nurse(s) would be responsible for going to the perspective unit(s) for the administration (intravenous and/or oral) of the medication. The pharmacist was unaware that an oncology patient was administered an expired dose of Dacogen.

Interview on 12/7/2023 at approximately 10:30 AM with oncology staff revealed that Patient #59 declined the first dose of Dacogen, which could have resulted in the administration of an expired medication.

Interview on 12/7/2023 at 11:00 AM with the Director of Quality revealed the Oncologist failed to enter an incident report and/or failed to speak to anyone regarding the administration of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 309}	Continued From page 114	{A 309}		

expired dose of Dacogen to Patient #59 that occurred 3/17/2023.

Interview on 12/7/2023 at 1:51 PM with the Oncology Unit Manager (OUM) revealed in April 2023 the oncology unit adopted a more detailed treatment administration checklist to assist the oncology nurses and the pharmacy department. The OUM further indicated she could not speak to the effectiveness of the updated checklist because no audits had been performed.

Telephone interview on 12/8/2023 at 3:00 PM with the Oncologist revealed providers were made aware after-the-fact of any problems or concerns. As related to the administration of expired medication to a patient, the oncologist revealed, efficacy should be the main concern which falls upon the pharmacy department and was pretty sure this was what happened in the case of Patient #59. Further inquiry revealed that since the hospital joined [name of organization], the oncology unit lost valuable nurses which led to the hiring of new/inexperienced staff, and increased use of travel staff. The changes in staff led to an increase in errors, especially with neutropenic patients, which resulted in a degradation in care. Additionally, in the past oncology patients were directly admitted to the oncology unit without emergency department presentation. Now, oncology patients were admitted through the emergency department secondary to closure of transfers, which put the oncology patients at an increased risk for infection. Additionally, the unit no longer admitted complex cases of oncology patients because those cases were referred to other hospitals. Further interview revealed pharmacy errors increased secondary to the loss of experienced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}	Continued From page 115 oncologist pharmacists. The interview concluded with the aforementioned concerns were voiced to the Medical Director for the oncology service line in which there were no notifications or any observations of changes. 4. Review of the closed medical record for Patient #50 revealed a 21-year-old female presented to the Emergency Department (ED) via law enforcement under IVC (involuntary commitment) for a "Psychiatric screening exam; Behavioral health concern." Review of the Provider Note dated 05/04/2023 at 1640 revealed "... patient presents with IVC paperwork and recent behavior concerning for danger to others in particular ... I will have behavioral health services see the patient ..." Review of the Initial Psychiatric Evaluation dated 05/06/2023 at 0531 revealed "The patient is a 21 yo (year old) female with h/o (history of) autism and mild intellectual disability, who was brought to the ED under VC due to increasingly aggressive behavior. The IVC paperwork reports (sic) that the patient has been going around the neighborhood with a hammer. She has done thoughtless things such as covering her father's eyes with his hat while driving and then kicking him. THe (sic) patient's behavior has been escalating since she could no longer participate in her programs during COVID 19 (pandemic). Instead of going to a group home, she was d/c (discharged) home from her last program. She has been increasingly irritable since she is swinging to calm herself down and has demonstarted (sic) dangerous behaviors ... Nursing reports pt (patient) became unexpectedly agitated this AM (morning), pulled nurse and sitter's hair after being asked if her ears hurt (she was pulling at them). She received 5 mg (milligrams) Versed (medication to help you relax)	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 309}	Continued From page 116 at time of arrival to the ED yesteay (sic) afternoon, but otherwise no PRN (as needed) medication. She has not required restraint ... She is mostly mute (refraining from speech), although sometimes echolalic (repeat others) and echopraxic (involuntary copying of another person's actions or movements). She waves when I wave. Says 'hello' when I say hello, and 'happy' when I ask if she is happy'(sic) ... Suggested plan; Uphold the IVC for now; observe the patient for the next 24-48 hours (sic); if the patient is stabilized, she can be discharged home or to a new placement, if one is available." Review of the Mental Health Contact Note dated 05/08/2023 at 1017 revealed "... reached out to Pt's mother, ..., and informed her that Pt was seen by Psychiatrist who is recommending discharge due to concerns of Pt safety on this unit, her aggressive behaviors w/ (with) other Pt's ..." Review of the Nurse Note dated 05/29/2023 at 0855 revealed "... This was the third time pt had attacked the hair of a sitter." Review of the Provider Note dated 05/29/2023 at 1007 revealed "...Patient was triggered by her sitter and attacked her this morning jumping on top of her and grabbing her hair ... Nursing staff reports this is the third sitter she is intact (sic) in the past 2 days ..." Review of the Nurse Note dated 06/10/2023 at 1920 revealed "Earlier today ... had multiple aggressive acts towards me, the first was when she spit on me as I was handing her a snack in the BHU (behavioral health unit) ... The second aggressive act came hours later when she saw me in the hall and came towards me. I attempted to walk away but she ran towards me, screaming and reaching for my face. She was able to pull the mask off my face but I restrained her hands and took several steps back, when she came after me again screaming and tearing at my head	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 309}	Continued From page 117 and face. I restrained her hands again and walked her back into her room towards her bed. As I let go and backed up ... leaned on her bed and kicked me in the chest with all her force ... I don't intend to escalate this matter any further and have explained the entire situation to the psych clinician." Mental Health Contact Note dated 06/18/2023 at 2100 revealed "... sitting in BHU intake office and heard yelling. Pt seen ... on camera gripping a male pt hair in ... hallway bed. Pt was standing over male pt's hallbed (sic), hand in male pt's hair shaking pt's head around. Male pt was yelling ... immediately came out of BHU intake office, pt ran back towards her room into her bed. Male pt was visibly upset and yelling at pt in her room ..." Nurse Note dated 06/18/2023 at 2130 revealed "Pt. ran out of her room and pulled hair/hit another pt who was in a hall bed. After getting loose the pt. ran after her back in to her room, a BERT (behavioral health emergency) was called, physician, RNs, psych clinicians, and security all responded. The pt who was attacked aggressively was shouting, punching the walls, and hitting her bed. We were able to de-escalate the situation and both pts. We moved the second pt. to a differed pod in his own room so he would feel safe. It is unsure if (Patient #50) was hit while he was hitting her bed, physician did an assessment and she has no obvious injuries or marks. Pts are both settled in separate areas now." Review of the medical record revealed Patient #50 was discharged to a facility on 06/20/2023 at 1659. Review on 12/05/2023 of the incident/variance reports provided regarding Patient #50 revealed there were no incident/variance reports for the incident on 05/29/2023 nor on 06/10/2023 to correspond with the incidents described in the	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 309}	Continued From page 118 medical record notes. There were incidents dated 05/27/2023 and 06/18/2023. Telephone interview on 12/06/2023 at 1400 with PSA #48 revealed she remembered Patient #50 and had to push her distress alarm button when caring for Patient #50. Interview revealed there had been several incidents involving Patient #50 pulling staff hair, attacking staff or other patients. Interview revealed PSA #18 had submitted incident/variance reports herself regarding more than one incident with Patient #50. Interview revealed there was a male patient in her room one time. PSA #18 could not remember the details about this incident, however confirmed she had filled out an incident report. PSA #18 stated there was a time when Patient #50 kissed another patient and an incident report should have been filled out about that. Interview on 12/06/2023 at 1500 with Director #82 revealed she only had four incidents/variances for Patient #50. Three of the four were dated 2022 and only one from 2023. Director #82 did not have the incident/variance provided to this surveyor dated 05/27/2023. Interview revealed the person entering the incident/variance did not enter the medical record number and Director #20 searched by the medical record number. Interview revealed it is hard to find incidents/variances if the medical record number is not entered so the information will pull across the system and make it easier to find. Interview revealed they can search by name however if the name is misspelled there would be problems finding any incidents/variances that were entered. Director #82 requested more time to research to see if there were more incidents/variances. At time of exit from facility on 12/09/2023 at 1600,	{A 309}		

{A 309} Continued From page 119 {A 309}

Director #82 had not provided any additional information to this surveyor regarding additional incidents/variances for Patient #50.

5. Closed medical record review of Patient #15 revealed a 21 year old male admitted on 08/14/2023 with abdominal pain. Record review revealed the patient had laparoscopic converted to open total abdominal colectomy (remove all or part of colon) with end ileostomy (stoma-opening in abdomen surgically created) on 08/27/2023 for ulcerative colitis. Record review revealed on 08/27/2023 at 1117 a ketamine drip was ordered stat (urgent). Record review revealed the patient arrived in PACU (post anesthesia care unit) at 1120. Patient transferred to floor (unit) at 1420. Record review revealed ketamine was started at 1448 on the unit. Patient returned to PACU at 1515 for ketamine drip. Review of nursing note on 08/27/2023 at 1526 revealed "Ketamine gtt (drip) sent to floor from pharmacy rather than to PACU. Patient arrived on the unit from PACU without ketamine gtt started. Notified (named) CNC (clinical nurse coordinator) and called to PACU nurse for patient to be transferred back to PACU for ketamine gtt initiation and required monitoring." Review of nursing note on 08/27/2023 at 1656 revealed "Pt (patient) transferred to floor after report called to RN (registered nurse). PT was ordered Ketamine and the pharmacy sent the medication to the nursing unit instead of PACU. RN agreed in report to start ketamine on pt arrival to floor, since the ketamine was on the unit. Pt later brought back to pacu when nurse became aware that she was not cleared by hospital regulations to start the ketamine gtt."

Review of a ketamine drip timeline document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 309}	Continued From page 120	{A 309}		

revealed Ketamine drip ordered at 1117. The order was verified by pharmacy at 1140, but the label was not printed. Missing medication request sent by the RN at 1228, high priority with comment "please bring to PACU pod 2 bay 9". Medication request was accepted by pharmacy at 1243 and label was printed. Label stated A3W/A336 as location. Medication hand delivered to staff and signed as received by the named RN. Ketamine drip documented as initiated at 1448. Review of ketamine delivery signature sheet revealed no time of acceptance documented.

Review of the incident/variance reports provided regarding Patient #15 revealed there were no incident/variance reports for the incident on 08/27/2023 to correspond with the incident described in the medical record notes.

Interview on 11/16/2023 at 1045 with RPH #87 revealed medications are sent to locations based on the patient's location in the medical record. Interview revealed when patients are in PACU the pharmacy staff rely on nursing to put in a missing medication request in order to get the drug to the correct location.

Interview on 11/16/2023 at 1230 with PA #90 who ordered the drip revealed the drip was supposed to be initiated as soon as possible. Interview revealed the ketamine drip should have been started before the patient went to the floor. Interview revealed "the periop phase can be tricky and the patient's location does not populate automatically."

Interview on 11/16/2023 at 1421 with RN #88 revealed the PACU staff had waited for hours for the pharmacy to fill the order. Interview revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 309}	Continued From page 121	{A 309}		

the medication had been delivered to the floor and not to PACU. Interview revealed pharmacy was called several times to inquire about medication, "So we thought they knew that the patient was in PACU since we kept calling."

Interview on 11/17/2023 with Nurse Manager (NM) #89 revealed ketamine drips are not done on the unit, they should be initiated on a higher level of care unit. Interview revealed the unit and pharmacy staff received education on which units can not initiate the ketamine drip. Interview revealed the education was in 12/2022. Interview revealed more education would be given to staff.

Interview on 11/27/2023 at 1540 with RPH #79 revealed the nursing staff would put in a medication request when they are ready for the medication to be prepared. The RN has to put in the location of the patient with the medication request. Interview revealed the pharmacy staff that processed the label may not be the same staff member that delivered the order, and the patient's location may not have been communicated to the delivery technician. Interview revealed the delivery technician would then go by the location that was printed on the label.

Request to interview a floor nurse revealed not available for interview.

Request to interview the unit CNC revealed not available for interview.

6. Review of a policy titled "Physiologic Monitoring-Cardiac Telemetry Monitoring..." with a revision date of 08/14/2023, revealed "Internal (lateral) transfers within the (named hospital). C.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 309}	Continued From page 122 Patients transferring to non-ICU (Intensive care unit) units with continuous ECG (Electrocardiogram) orders will transport on continuous ECG. 2. The receiving RN will notify CMU (cardiac monitoring unit) with patient name/MRN (medical record number), room being transferred to and telemetry box being assigned." Closed medical review on of Patient #13 revealed a 76 year old male admitted on 08/19/2023 at 1430 for hypertension (high blood pressure) and Intracranial hemorrhage (brain bleed). Review of RN #53's note written on 08/25/2023 at 1750 revealed "Transferred to Floor. Transfer Report Given to (RN #54). Transport equipment: Monitor. Mode: Wheelchair." On 08/25/2023 at 1934, Patient #13 was transferred to a stepdown unit. Review on 11/15/2023 of an incident report written by CMU supervisor #52 revealed (Patient #13)" had active 48 hr (hour) tele (telemetry) orders from 08.24.2023 at 1348 but were (sic) not being monitored." Review of telemetry strips failed to reveal a telemetry strip for evening hours of 08/25/2023. Review revealed Patient #13 was not monitored by telemetry for 6 hours. Review of a Safety Event Timeline dated 08/29/2023 at 1408 from Manager #56 from Floor A revealed "Status: Assigned to Manager #55, Manager of Floor B (sending floor manager)." Review revealed on "08/31/2023 at 1234, Status: Assigned. Closed." Review revealed no further documentation from Manager #55. Review revealed no documentation of the investigation of the Patient #13 without telemetry monitoring. Interview on 11/15/2023 at 1605 with CMU supervisor #52 revealed a daily audit is conducted at 0100 and 1300 of telemetry patients	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE** **ASHEVILLE, NC 28801**

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{A 309}	Continued From page 123 to ensure patients are being monitored as ordered. Interview revealed Patient #13 was found to have an order for telemetry but was not being monitored. Patient #13 had not been monitored since transfer to another floor on 08/25/2023 at 1934. Interview revealed Patient #13 was placed on telemetry on 08/26/2023 at 0139, 6 hours and 5 minutes after transfer to the floor. Interview on 11/28/2023 at 1234 of RN #54 revealed no recollection of Patient #13 or details of the transfer. Interview revealed RN #54 had not been interviewed regarding the incident of Patient #13. Interview on 11/28/2023 at 1633 of RN #53 revealed no recollection of Patient #13 or details of the transfer. Interview on 11/30/2023 at 1645 with Risk Manager #58 revealed "incidents should be reviewed and escalated to the department leaders. There should be notes from the manager." Interview of Manager #55 was not obtained due to no longer employed. In summary, Patient #13 was transferred to Floor B with telemetry orders. After 6 hours, Patient #13 was discovered without telemetry. There was no review of the incident from the management of the sending floor or risk management. 7. Medical record review on 11/14/2023 of Patient #2 revealed the patient arrived to the Emergency Department (ED) on 10/17/2023. Review of the EMS Patient Care Record revealed	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 309}	Continued From page 124 EMS received a call at 1654, arrived to Patient #2's home at 1720 and transported the patient to the hospital, arriving at 1748. EMS documented they transferred care of the patient to the hospital at 1907, 1 hour 19 minutes later. Prior to the transfer of care, review revealed EMS continued monitoring Patient #2. A note in the EMS record indicated "Turn Around Delays.....ED Overcrowding/ Transfer of Care......." The hospital emergency department record review revealed the patient arrived at 1753 via EMS, with complaints of chest pain, shortness of breath, and syncope. Patient #2 was noted as evaluated by a provider at 1845 (52 minutes after arrival) and triaged by a RN at 1900 (1 hour, 7 minutes after arrival). An EKG was completed at 1905 (1 hour 12 minutes after arrival) and labs, including troponin, were drawn at 1920 (1 hour 27 minutes after arrival). Record review revealed a delay in the hospital accepting the patient from EMS, triaging and initiating care to the patient, including an EKG and labs. Patient #2 went into cardiac arrest at 1953 (2 hours after arrival) and subsequently expired after failed resuscitation attempts. Review of a document received from the hospital related to this patient, on 11/16/2023, revealed it was not dated or timed and was not signed. Document review revealed the following statement: "I have reviewed this case and the initial presentation, the timing on the workup, the findings and escalation were all appropriate and met standard of care. The patient arrived at 1753, was roomed at 1830 and was seen by a clinician at 1845 the patient coded at 19:53 and had a time of death at 22024 (sic) all of which occurred while in a room. The EKG was reviewed by the initial	{A 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 309}	Continued From page 125	{A 309}		

clinician and reported in the chart. The patient coded at 1953 and Dr. (Name) was called to the Code. During the code Dr. (Name) has documented that the patient had brief return of consciousness with the ongoing CPR. During this time he began reviewing the workup and the EKG, which was handed to him at 2002. It was read as sinus rhythm with a PVC and a 4 beat run of non-sustained ventricular tachycardia. He signed this EKG at this time 2002, the code was continued for another 22 minutes before time of death." There were no other notations on the received document including no identification of who completed it or when. The document did not identify any areas of concern. There was no documented review of the timing of triage or implementation of orders. Additional information on the document was requested on 11/17/2023. No updated information was received.

Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed EMS was able to give hand-off report to a nurse at 1907 (over an hour after arrival). Interview revealed wait times for EMS to hand-off patients had recently gotten more common.

Telephone interview with RN #66, on 11/16/2023 at 0938, revealed that until patients were in a room and care handed-off from EMS, they were "counting on EMS to care for (the patients). ...."

Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the goal for screening evaluations was 20 minutes from arrival.

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed the expectation for chest pain patients was an EKG within 10 minutes and to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 309}	Continued From page 126 seen by a provider within 10 minutes. MD #72 acknowledged a delay with Patient #2. Interview revealed the physician was not aware if there was a review of the case. Review of documents received did not reveal an incident report. Review of findings and document provided revealed the hospital failed to identify and evaluate delays in accepting, triaging and initiating care and treatment for a patient presenting via EMS with chest pain.	{A 309}	**Subject of Deficiency – A 385** The hospital's nursing staff failed to have an effective nursing service providing oversight of day to day operations by failing to ensure systems were in place to supervise and provide safe delivery of care to patients presenting to the emergency department (ED). Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below. **Immediate Corrections and System Changes** **Immediate Actions Taken:** Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings: 12/1/23-	
{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 policy review, medical record review, incident report review, EMS trip report review, and staff and provider interviews, the hospital's nursing staff failed to have an effective nursing service providing oversight of day to day operations by failing to ensure systems were in place to supervise and provide safe delivery of care to patients presenting to the emergency department (ED). The findings included: 1. The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the emergency department for 4 of 35 sampled ED records reviewed (Patient #'s 28, 43, 27, and 2).	{A 385}	Added further financial incentives for trained and competent staff to pick up in the ED above their current commitment. These departments included: phlebotomy, MedCom, Monitor Techs, Transport, EVS, Guest services, and Registration (Patient Access Services) staff. 12/2/23 -Leadership meeting to determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing Officer's, and Vice President of Emergency Services. Actions taken specific to staffing from that meeting: • Developed and implemented a schedule for expanded ED leadership coverage to include weekends and nights • Requested a performance improvement review of ED staffing and efficiencies • Outlined and educated ED staff (RN, CNC, Paramedic, PCT's, HUC, and ED Leadership) around triage escalation process and deployment of additional triage team members when necessary. Education provided by CNC, Educators, and ED Leadership. • Added ED Interim leaders. 12/4/23 Deployment of Emergency Department Performance Improvement team to evaluate staffing, processes, and provide recommendations. 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).	12/2/23 12/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 385}	Continued From page 127	{A 385}	12/8/23 Added further financial incentives for as needed staff and travelers to pick up additional shifts above their current commitment.	12/8/23
	Cross refer to 482.23 Nursing Standard: Tag A 0392.		12/9/23 On site survey ended with DHHS with disclosure of two additional concerns under the same conditions of participation (Emergency Services, Patient Rights, and Nursing Services).	12/9/23
	1. The hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for 11 of 35 ED records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26).		12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses.	12/12/23
	Cross refer to 482.23 Nursing Standard: Tag A 0398.		12/16/23 Incident Command Structure established with Daily Emergency Operations Coordination Call (DEOCC) with hospital and additional leadership to review the following: Hospital and ED volumes, review of ED and inpatient metrics related to throughput, Inpatient and ED staffing, support staffing, HR and recruitment updates, and staffing requests. The goal of this call was to quickly obtain approval to mitigate barriers, as well as to have continuous oversight at all levels of the organization.	12/16/23
	2. The hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered and evaluate and monitor the effects of the medication for six (6) of 35 patients presenting to the emergency department (Patient #'s 92, 83, 43, 28, 27, and 26).		12/17/23 Emergency Operations Team on site to provide continuous support of Emergency Operations.	12/17/23
			12/18/23 Three inpatient leaders were redeployed to assist with oversight in the emergency department.	12/18/23
	Cross refer to 482.23 Nursing Standard: Tag A 0405.		12/19/23 Exit conference with DHHS team and letter receipt which included the following information: that the state was recommending 23-day termination due to noncompliance with the COP's of Emergency Services, Patient Rights, Nursing Services, as well as, Governing Body, Laboratory Services, and Quality Assurance. We were informed that CMS office in Atlanta would make the final determination regarding compliance or non-compliance with the COP's. No additional detail was provided at that time.	12/19/23
{A 392}	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b)	{A 392}		
	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		12/21-12/29 ED and Inpatient staffing rapid response nurses deployed to Mission Hospital. A rapid response nurse is, a nurse who is able to arrive within approximately ten days of notice. They are competent in their area of specialty and complete traveler orientation on arrival to the facility. These resources were in addition to the travelers already in place throughout the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 392}

Continued From page 128

nurse for care of any patient.
This STANDARD is not met as evidenced by:
Based on policy, medical record review, incident report review, and staff and provider interviews, the hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the Emergency Department (ED) for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26).

The findings included:

Cross refer to §482.55 Emergency Services Standard: Tag 1101.

The ED nursing staff failed to ensure emergency care and services were provided according to policy and provider orders. Patients were not accepted upon arrival to the ED, evaluated, monitored and provided treatment to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26.

1. Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization

{A 392}

The primary focus of this deployment was to open up inpatient capacity, assist in the ED with shift coverage, and supplement current staffing until additional permanent staff could be hired and onboarded.
12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. — 12/29/23
1/2/24 Increased overall ED traveler RN's based upon a continual assessment of ED staffing and onboarding.

Ongoing Actions and System Changes
1/11/2024 Comprehensive review of ED assignments/shifts resulted in modifications to better accommodate patient arrival patterns via EMS and walk-in.
1/1/2024-2/1/24 The following resources/actions were taken to continue to address staffing in the Emergency Department:

- Additional interim leadership was added.
- Added dedicated ED transporter at peak times.
- Added ED Central Monitoring Unit(CMU) resource at peak times.
- Departments that had incremental additions (i.e. travelers) to support the ED were: MAMA Ground Ambulance Transport, in-house transport, Environmental Services, Case Management, Phlebotomy, Respiratory Therapy, Physical Therapy, and the Central Monitoring Unit.
- Evaluated and modified front-end triage process to better align resources with patient arrival patterns.
- Modified closure review tool to increase sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department.
- Real time staffing is reviewed by the Charge RN, Administrative Supervisors, Nursing Leadership, and Staffing Coordinators to support patient acuity changes and/or adjust patient volumes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

{A 392}

Continued From page 129

at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented.

2. Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on

{A 392}

- There is a rounding Administrative Supervisor who works directly with the staffing coordinators on a 24/7 basis to support staffing decisions to align with both census and overall patient care needs.
- The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.
- Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be provided, and the caregiver competency and scope of nursing practice.
- Mission hospital is continuously recruiting and making efforts to retain current employees. Year to date (2024) Mission hospital ED has hired 17 RN positions, 2 CNC positions, and 4 StaRN (New Nurse) positions.

2/1/2024 Transmittal of 2567 received from CMS to Mission Hospital CEO — 2/1/24

Monitoring for Compliance:

If the number of staff available does not meet the needs of the ED due to surge, call-outs, etc., in a given shift the hospital evaluates staffing utilizing the following processes:

- The patients on each unit are evaluated based on their acuity and level of care and assignments are adjusted as appropriate.
- Charge nurses are utilized to deliver direct patient care
- Staff who are not working are asked to pick up through various communications in advance as well as throughout the shift as appropriate
- Staffing is reevaluated at a minimum of every 4 hours to determine if resources can be shifted as appropriate
- Unit capacity is determined by Nurse staffing office in conjunction with Administrator-On-Call (AOC)
- Hospital closure to incoming transfers and out of county EMS volume is determined at a minimum of 4 times a day by AOC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 392}

Continued From page 130
11/30/2023.

3. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury.

4. Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and

{A 392}

- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP of Emergency Services

Subject of Deficiency – A 392
The hospital's emergency department staff failed to ensure adequate nursing staff was available to provide and monitor the delivery of assessments, care, and treatments in the Emergency Department (ED)

Each individual Condition of Participation's cross-referenced tag in this section will be outlined in the appropriate tags section below.

Immediate Corrections and System Changes:
Immediate Actions Taken:
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings
12/2/23 -Leadership Meeting to Determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing Officer's, and Vice President of Emergency Services. Applicable actions taken from that meeting include:

- Developed and implemented education as outlined below
- Implemented a timestamp process to accurately capture the arrival time of patients at triage
- Development of audit tool to track timely care delivery through arrival to triage, order to lab collect, pain medication assessment/reassessment, order to intervention
- Developed and implemented timely and frequent real time communication structure involving ED CNC/ED leadership oversight to include: safety, patient throughput, pending medications/reassessments/ diagnostics and escalations via internal communication tool.

Completion date: 12/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 392}

Continued From page 131

the PA indicated the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest.

5. Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in

{A 392}

- Developed and implemented a schedule for ED leadership coverage to include weekends and nights
- Requested and received additional incentives for ED staff, support staff, and inpatient staff to pick up extra shifts.

12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).

12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses. — 12/12/23

Additional immediate and ongoing actions:
Designated inpatient nursing to care for inpatient holds and provide care within their designated scope/competency in the emergency department as needed. Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be provided, and the caregiver competency and scope of nursing practice.

- Requested additional inpatient and emergency department rapid travel nursing staff.

System Changes:

- Evaluated front-end triage process to better align resources with patient arrival patterns. Assembled a team to include (pharmacy, radiology, lab, patient access, care experience, emergency department nurses, providers, IT, nursing administration, emergency department leadership),
  - Staffing Adjustments: Added a second triage nurse during peak times, second charge nurse for waiting room/ internal processing area, assembled two intake teams to assist with patient care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 392}	Continued From page 132 condition (not breathing). 7. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff. 8. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs	{A 392}	implementation and waiting room throughput. Staffing assignment sheets adjusted to reflect the new changes. o Converted front end rooms to optimize new front-end process o Implemented quick registration and rapid triage process o Educated staff (RNs, CNCs, Paramedics, PCTs, HUCs, and ED Leadership) on new front-end process, medication verification (as required by specific scope), tracking and trending outcomes with data o Educated providers as outlined above as applicable per scope o Worked with pharmacy to standardize medication storage units o Worked with laboratory services on available equipment and identified additional resources needed o Data reviewed every two hours with issue and action closed loop communication, daily action plan for task and assignment review Increased leadership coverage to include weekends and nights to maintain oversight of emergency department operations • Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. • Modified closure review tool to increase sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department • Real time staffing is reviewed at AM and PM staffing assignments by the Charge RN, Administrative Supervisors, Staffing Coordinators, Performance Improvement Team, and Nursing Leadership to support patient acuity changes and/or adjust patient assignments as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 392}

Continued From page 133

by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment.

10. Patient #26 presented to the ED via EMS on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.

11. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. Record review revealed the patient did not have her vital signs monitored and had no nurse assigned to monitor status or provide care.

{A 398}

SUPERVISION OF CONTRACT STAFF
CFR(s): 482.23(b)(6)

All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate

{A 392}

- The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.

Monitoring for Compliance/Audit Details:
Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:
- o Arrival to Triage Times for walk-in and EMS
- o Arrival to EKG order-to- complete per policy/protocol
- o Pain Medication assessment/ reassessment per policy/protocol
- o CIWA assessments per policy/protocol
- o Realtime escalation of patient safety concerns
- o CT order to exam

Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)
- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

{A 398}

Monitoring and tracking of EKG order-to- completion per policy/protocol
- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 398}	Continued From page 134 supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on policy review, medical record review, incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders for eleven (11) of 35 patients records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). The findings included: Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS: ... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance,	{A 398}	• Numerator = # of compliant EKG order- to-completion per policy/protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol Goal of 90% compliance with 100% remediation of outliers/deviation from • process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of pain medication assessment/reassessment per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of CIWA assessments per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}

Continued From page 135

eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. 2. A comprehensive assessment, performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale, allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief

{A 398}

Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team

- Facilitation of early event identification for timely investigation/action as appropriate
- Monitor for trends
- Ensures routing of events to appropriate parties for review
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers

- Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO/VP Emergency Services

Subject of Deficiency: A 398
Hospital nursing leadership staff failed to ensure policies were implemented to evaluate, monitor and provide treatment for patients presenting to the emergency department resulting in delays and lack of triage, nursing assessment, monitoring, and implementation of lab, telemetry, medication and treatment orders.

Plan of Correction:
Summary of policies/guidelines and any other documents reviewed or revised during POC development:

- Assessment/Reassessment, 1PC.ADM.0013
- Pain Assessment and Management, 1PC.ADM.0002
- Physiologic Monitoring – Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring, Non- Invasive Blood Pressure Monitoring (NIBP), 1PC.NRS.0001
- Triage – Emergency Department, 1PC.ED.0401
- Triage Treatment Guidelines – TTGs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 398}

Continued From page 136

evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the patient will need to wait in the lobby. While in the lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines....."

Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. .... The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated and immediate life-threatening needs are determined with

{A 398}

- 1PC.ED.0402
- CIWA Withdrawal Plan 2/22

Immediate Corrections and System Changes:
Immediate Actions Taken:
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1/23 the following actions were taken to mitigate the findings
12/2/23 -Leadership Meeting to Determine areas of focus and next steps. Attendees: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, D. Chief Medical Officer, Assistant Chief Nursing Officer's, and Vice President of Emergency Services. Applicable actions taken from that meeting include: — 12/2/23

- Developed and implemented education as outlined below
- Implemented a timestamp process to accurately capture the arrival time of patients at triage
  Development of audit tool to track timely care delivery through arrival to triage, order to lab collect, pain medication assessment/reassessment, order to intervention
- Developed and implemented timely and frequent real time communication structure involving ED CNC/ED leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
- Developed and implemented a schedule for ED leadership coverage to include weekends and nights
- Requested and received additional incentives for ED staff, support staff, and inpatient staff to pick up extra shifts.

12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign).
12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was — 12/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE

{A 398}

Continued From page 137

appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial, physiological, and age-specific needs of the individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...."

1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in

{A 398}

prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses

Additional immediate and ongoing actions:

- Designated inpatient nursing to care for inpatient holds and provide care within their designated scope/competency in the emergency department as needed. Staffing assignments for patient care are based on the level and scope of care that meets the acuity needs of the patient population, the frequency/intensity of care to be provided, and the caregiver competency and scope of nursing practice.
- Requested additional inpatient and emergency department rapid travel nursing staff.

System Changes:

- Evaluated front-end triage process to better align resources with patient arrival patterns. Assembled a team to include (pharmacy, radiology, lab, patient access, care experience, emergency department nurses, providers, IT, nursing administration, emergency department leadership),
    - Staffing Adjustments: Added a second triage nurse during peak times, second charge nurse for waiting room/ internal processing area, assembled two intake teams to assist with patient care implementation and waiting room throughput. Staffing assignment sheets adjusted to reflect the new changes. optimize new front-end process
    - Implemented quick registration and rapid triage process
    - Educated staff (RNs, CNCs, Paramedics, PCTs, HUCs, and ED Leadership) on new front-end process, medication verification (as required by specific scope), tracking and trending outcomes with data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 398}	Continued From page 138 waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and labs including CBC, chemistry, lipase and troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023	{A 398}	o Educated providers as outlined above as applicable per scope o Worked with pharmacy to standardize medication storage units o Worked with laboratory services on available equipment and identified additional resources needed o Data reviewed every two hours with issue and action closed loop communication, daily action plan for task and assignment review o Increased leadership coverage to include weekends and nights to maintain oversight of emergency department operations o Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. • Modified closure review tool to increase sensitivity to surges in ED and inpatient volumes. Changes include the addition of sensitivity indicators for patients with consult for admission order. Additional sensitivity indicators added for total number of behavioral health patients in the department. • Real time staffing is reviewed at AM and PM staffing assignments by the Charge RN, Administrative Supervisors, Staffing Coordinators, Performance Improvement Team, and Nursing Leadership to support patient acuity changes and/or adjust patient assignments as appropriate. • The Administrative Supervisor is aware of high acuity needs, ED surge alerts, and overall operational needs in the hospital. The Administrative Supervisor adjusts staffing assignments based on this awareness.	

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{A 398}	Continued From page 139 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization.	{A 398}	**Education:** Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. **Education has been incorporated into new hire and contract staff education**. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions. • 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals • 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight • 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals • 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol • 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment • 12/21/2023 ED nursing staff education regarding telemetry order initiation • 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process • 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff • 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway	12/2/23 12/2/23 12/2/23 12/2/23 12/14/23 12/21/23 12/21/23 12/21/23 12/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 398}

Continued From page 140

..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis of STEMI (ST elevation myocardial infarction), Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR.

Interview on 12/09/2023 at 1210 with Assistant Director of Nursing (ADON) #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor.

In summary, Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate. Findings of an EKG at 2110 showed ST elevation, **ACUTE MI/STEMI**. A STEMI Code Activation was initiated for an evolving lateral STEMI. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous

{A 398}

- 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversation with nursing staff completed by education team — 1/15/24
- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front- end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24
- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation — 2/6/24

Monitoring for Compliance/Audit Details:

Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Daily monitoring of performance for the following:

- Arrival to Triage Times for walk-in and EMS
- Arrival to EKG order-to- complete per policy/protocol
- Pain Medication assessment/ reassessment per policy/protocol
- CIWA assessments per policy/protocol
- Realtime escalation of patient safety concerns
- CT order to exam

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{A 398}	Continued From page 141 telemetry. 2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. "	{A 398}	Sustained Compliance Audits to Ensure POC is Effective: Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS) • The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant arrival-to triage times per policy/protocol • Denominator = 70 observation per month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring and tracking of EKG order-to- completion per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant EKG order- to-completion per policy/protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)	

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{A 398}	Continued From page 142 Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of dizziness from her doctor's office. Patient #83 was seen by an ED Medical Doctor (MD) #1 on arrival and at 1218 a comprehensive metabolic panel (CMP) [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 Registered Nurse (RN) #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14	{A 398}	Monitoring of pain medication assessment/reassessment per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of CIWA assessments per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team • Facilitation of early event identification for timely investigation/action as appropriate • Monitor for trends • Ensures routing of events to appropriate parties for review • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers • Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) **Owner:** Chief Nursing Officer/ACNO/VP Emergency Services	

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{A 398}	Continued From page 143 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an inpatient bed. At 2329 Hospitalist MD #9 ordered an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). On 11/29/2023 at 0127 MD #9 ordered a Lactic Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these , later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 canceled the 0127 NOW Lactic Acid order "nurse collect" from	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 398}	Continued From page 144	{A 398}		

the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes after ordered) with result of 12.3 (normal high range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was in the lab for processing at 0907, and resulted at 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337.

Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 145	{A 398}		

description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work.

MD #9 was unavailable for interview.

MD #16 was unavailable for interview.

Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed.

Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 146	{A 398}		

getting in contact with the phlebotomist. That morning they were not logged into to their imobile device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on 12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 147 hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I strongly advocated for her to get moved into a bed with the CNC (clinical nurse coordinator), and it didn't happen. She didn't think it was a big deal. We don't have the capability to link the patient to a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, RN #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83. Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 148	{A 398}		

within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83.

Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was canceled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.

3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 149 Withdrawal Plan, effective date 07/20/2022 revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less than) 15..." The CIWA/Alcohol Withdrawal Plan Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10. Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..." Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure 141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, EKG, and chest X-ray were completed, and Patient #43 was assigned to ED	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 150 Medical Doctor (MD) #23. Review of the ER Physician Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, EKG and chest X-ray results from 08/14/2023 did not show any critical results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4 mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1 mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1 mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 151 a CIWA Scale reassessment was due to be completed per protocol. No nursing reassessments, medication administrations, IV access/fluids, or physician orders were completed after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4 mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 152	{A 398}		

documented before the patient had a seizure event with sustained head injury. There was no nursing reassessment, or nursing care after 08/14/2023 at 1851 by RN #22 until 08/15/2023 at 0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at 0334 from the ED. Patient #43 was discharged home on 08/17/2023.

Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to sent out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload."

MD #23 declined to be interviewed.

Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 153	{A 398}		

monitored ..." Interview revealed MD #26 had concerns for patient safety in the ED waiting room due to delays in patient monitoring.

Interview on 11/15/2023 at 1615 with Nurse Practioner (NP) #36 revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room.

Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration.

Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would

{A 398} Continued From page 154 {A 398}

fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43.

Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43.

Interview on 12/08/2023 at 1230 with Nursing Vice President of ED Services (VPED) #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 155 been completed. Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 156 severity index (ESI) of 1-Resuscitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG, lab work, chest X-ray and CT (cat scan) of the head. At 1005 Haldol (given to treat severe behavior) 10 mg Intravenous was ordered by MD #59 and given due to combativeness. Review of the ER Note by MD #59 dated 07/05/2023 at 1002 revealed ".....history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now,... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm 3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed .. The Head CT	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 157 was negative...Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes...We have been running norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4 mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20 mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 158 showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040. Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assignment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 159 respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients.	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 160 Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 398}	Continued From page 161	{A 398}		

was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation.

ED RN #68 was not available for interview.

ED RPH #78 was unavailable for interview.

ED Manager RN #75 was unavailable for interview.

ED Director, RN #76 was unavailable for interview.

Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 398}	Continued From page 162	{A 398}		

patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available).

Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 163	{A 398}		

resources..." Further interview with CNC RN #74 revealed "...she had no concerns with nursing reassessments in the ED... that nursing assignments in the Red Pod (where the most acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care.

Interview on 11/15/2023 at 1637 VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed.

Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 164	{A 398}		

person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him.

Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did.

Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 165 the patient was not the PA's assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest. 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 166 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5 mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136. Request for a Patient Safety Report (Incident Report) revealed there was not one available. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 167 patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022. Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room. Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
{A 398}	Continued From page 168	{A 398}		

Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters (ml). Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER (emergency room) Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 169 medication, antibiotics, and lab work." PA #45 ordered X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients) Hallway Bed 7. At 1517 Patient #29 was triaged by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2 (oxygen) 20g (gauge) Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), Registered Nurse, (RN) #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4 mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5 mg IV for a pain score of 10/10 and Zofran 4 mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 170 reassessment was charted as 9/10 (no evidence of an oxygen reassessment). At 1748 the Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open tibial shaft fracture..." with plan for surgery to repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5 mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (do not resuscitate) [no evidence of this in the record]. She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 171 1909. Review of the Patient Event Record dated 04/06/2022 at 0341 by Nursing/Surgical Services #54 revealed the event was "unexpected death" date of event "04/05/2022 at 1903" with narrative "...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsive in hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to event per report. Trauma Nurse, RN #56 was unavailable for interview. Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 172	{A 398}		

policy for reassessment was not followed for Patient #29.

Telephone interview on 11/16/2023 at 1324 with MD #46 revealed she did not recall Patient #29. Interview revealed "...monitoring of patients in hallway beds are a concern. Ideally every patientin the Red Pod should be on some sort of a monitor with a pulse oximeter (oxygen monitor). More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside.

Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29.

Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 173 placed on a cardiac monitor which showed asystole. At 1909 was the time of death pronounced with her daughter at the bedside. Interview revealed this event was reviewed by the Mortality and Morbidity which was comprised of multiple providers and the MD who had completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.) Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and again at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing). 7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 174 weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood thinners and 10 days post partum. What aspect of reason for visit is concerning to patient? : Stroke symptoms. ..... " Review of a MD "ER Report", service date/time 10/03/2023 at 1714, revealed " .... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 175 deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the fact the patient is 10 days postpartum which does place her at an elevated risk for ischemic CVA (stroke). Differential at this point would also include complex migraine, preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke. ..... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 176 urgent transport) ......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no obvious distress....report is as follows: .....Dx (Diagnosis): HTN (hypertension) crisis, Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and weakness and tingling onset....10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 177 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and leg weakness along with a facial droop and neck pain. Vital signs continued approximately every 5 minutes, with the last recorded blood pressure 147/90 at 2215. Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H.....ED Full Triage Arrival Mode - ED (Emergent) : EMS.....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital....." Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form. ... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 178 neurologist decision was made against using tPA (breaks down blood clots). She was transferred here for further stroke eval and MRI (magnetic resonance imaging). She was also notably hypertensive at outside hospital with blood pressure 160s systolic. She has also had some headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here.	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 179 Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop Preeclampsia...... " Record review failed to reveal acceptance and monitoring of Patient #6 by nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023. Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring.	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 180 Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible." Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia. Telephone interview with Patient #6's Triage	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 181 Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation. Interview revealed the EMS team was responsible for any patient they brought in until the patient got a room assignment and was moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Telephone interview on 11/17/2023 at 1205 with MD #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics. In summary, Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be	{A 398}		

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{A 398}	Continued From page 182 managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed " ...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed ".... History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)...... Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with	{A 398}		

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{A 398}	Continued From page 183 neurologic symptoms concerning for acute ischemic stroke.....I think she will likely be a candidate for thrombolytics assuming that we can get her blood pressure down. She is going to CAT (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. ...." Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority. Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). ..... THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 184 PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED ....THE PHYSICIAN ADVISED TARGET BLOOD PRESSURE IS 140/90 AND ADVISED TO MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE..... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT .... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED ......" Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A 398}	Continued From page 185 hand-off to the hospital. Review of the Hospital A medical record for Patient #1, on 11/14/2023, revealed the patient arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351, revealed " ... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management ....Physical Exam ....Initial Vitals No Data Available ... Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making ..... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ...." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated " ...Impression and Plan:...... #ICH (Intracranial Hemorrhage): hypertensive etiology suspected .... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 398}	Continued From page 186 one side of the body). Plan: admit to ICU for close neurologic monitoring. ..." Review of the ED record failed to reveal any vital signs or assessments by nursing. Review revealed "Nurse Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by (Name), RN. ED CNC (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85. Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED. Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a	{A 398}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 187	{A 398}		

concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients in the ED as soon as they were notified of the patient's arrival. Interview revealed it was "surprising" not to have vital signs completed in the ED and stated it did not meet expectations for care - patients needed hourly neuro checks and vital signs with provider updates on changes.

Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN.

Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 188	{A 398}		

was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED.

9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 189 FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE BIG TOE OF HIS LEFT FOOT. IT WAS NOW NOTED THAT PT'S EKG WAS SHOWING ....ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY A&Ox4 PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN. ....." EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 190	{A 398}		

on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care ......"

Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7.

Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed " ... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks .....He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic , Diflucan (antifungal), and Duricef (antibiotic). ....Medical Decision Making...... EMS reports that they gave patient 324 mg aspirin...... blood pressure was approximately 96 mmHg. They

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
{A 398}	Continued From page 191 gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that patient had 7 beat run of V tach on their EKG tracing in route with patient now in sinus rhythm and occasional bigeminy. Ordered EKG and for patient to be on telemetry .....Point-of-care CBG (blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach ... 1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017 .... Called lab to request results of chemistries be available as soon as possible. Labs resulted after arrest .... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack). Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 192 after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm .....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 193 opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For this patient who presented with chest pain, syncope, and suffered cardiac arrest has either suffered an MI or rhythm disturbance..... I reviewed his medications..... I made attempts to address .....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole .....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46 ... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest. ..." Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17	{A 398}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 398}	Continued From page 194	{A 398}		

minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently and it seemed like a staffing issue.

Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the patient came into the ED with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival.

Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE

{A 398} Continued From page 195 {A 398}

#2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in a room and care handed-off from EMS, interview revealed, they were "counting on EMS to care for (the patients)......"

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started.

Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 398}	Continued From page 196	{A 398}		

resulting in delayed triage, care and treatment.

10. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival).

Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 398}	Continued From page 197	{A 398}		

case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be seen by providers and prescribed medications while "on the wall" but can not get them because no RN has been assigned.

11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention".

Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment..."

Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 398}	Continued From page 198 ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	{A 398}		
{A 405}	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or	{A 405}	**Subject of Deficiency: A 405** Hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered, and evaluate and monitor the effects of the medication Each individual Condition of Participation plan of correction for the cross-referenced tag in this section are outlined below.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE

{A 405}

Continued From page 199

practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.
This STANDARD is not met as evidenced by:
Based on policy review, medical record review, incident report review, EMS trip report review, and staff and provider interviews, hospital nursing staff failed to administer medications and biologicals according to provider orders and standards of practice by failing to administer medications as ordered, and evaluate and monitor the effects of the medication for 6 of 35 patients presenting to the emergency department (#92, #83, #43, #28, #27, and #26).

The findings included:

Cross refer to A-0398 for all examples.

Review of a "Pain Assessment and Management" policy revised 01/05/2022 revealed, " ... Each patient is screened for the presence of pain in all settings where treatment is provided.......3. For

{A 405}

Plan of Correction:

Immediate Actions Taken
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:

- Medication Administration Assessment/Re-assessment Completed as indicated — 12/2/23
  - 12/2/2023 Staff education with attestation
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight.
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool.

Education:
Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms.
These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. **Education has been incorporated into new hire and contract staff education**.
Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

{A 405}

Continued From page 200

emergency departments (ED), patients will be screened for pain during each ED visit. ...... The frequency of pain assessment is based on patient symptoms, interventions, and progress towards goals....... Interventions are provided based on the patient's treatment plan for pain. ......The pain management/treatment plan is evaluated on an ongoing basis and is revised to facilitate achievement of pain goals based on best practices, patient's clinical condition, past medical history, and pain goals......... Pain rating must be documented prior to the administration of PRN pain medication. If opioids are administered, sedation level must also be documented. Pain rating and sedation levels are reassessed within 1 hour after PRN pain administration by any route. If opioids are administered, sedation is evaluated to assess for opioid-induced respiratory depression using one of the following sedation scales: 1. For the non-ICU, non-intubated patient (adult and pediatric), the Pasero Opioid-Induced Sedation Scale (POSS) should be used. ..... The pain/treatment plan is evaluated on an ongoing basis and is revised to facilitate achievement of pain goals. "

Review of a "Medication Administration" policy revised 03/20/2023 revealed, ".....Pain medications may be administered to treat or prevent pain. Proactive pain management is preferred to reactive......For opioid medications ordered "as needed for pain" the level of pain for administration must be specified in the order. 1. If the patient's symptom is unrelieved, the nurse may administer additional doses of PRN (as needed) medications ordered, not to exceed the maximum dose within the prescribed frequency. 2. Subsequent doses are based on the nurse's assessment, the patient's response to the

{A 405}

- ED nursing staff remedial education with attestation post-opiate medication administration assessment
- ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles.

Action:

- Timely and frequent communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
- ED tracking board enhancements to include vital sign, telemetry, pain reassessment, and EKG icons
- EHR enhancement of visual cue to prompt staff to better capture post- medication administration assessments

Monitoring for Compliance/Audit Details: The monitoring and tracking procedures that will be implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.
Routine monitoring of pain medication assessment/reassessment per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
Denominator = 70 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Routine monitoring of CIWA assessments per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
Denominator = 30 audits/month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Nursing Officer/ACNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 405}	Continued From page 201 previous dose, absence of adverse effects, and symptom severity. ..... Monitor the patient's response. ....." 1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .. " Review revealed a pain level reported as 2 (scale 1-10 with 10 the worst). Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to administer a dose of aspirin. A baby aspirin was administered as ordered at 1334. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented.	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 405}	Continued From page 202	{A 405}		

Interview on 12/09/2023 at 1210 with Assistant Director of Nursing (ADON) #17 revealed no nursing assessments or reassessments were documented in the ED record.

2. Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on 11/28/2023 at 1216 with a chief complaint of dizziness. Review revealed a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the Registered Nurse (RN) #3 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). At 2329 Hospitalist Medical Doctor (MD) #9 ordered an IV infusion of D5 1/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). At 0157 RN #10 documented the IV with D5 1/2 NS KCL as started (2 hours and 27 minutes after ordered).

Interview on 12/08/2023 at 1425 with RN #3 who cared for Patient #83 on 11/28/2023 revealed physician orders were not followed for Patient #83.

Interview on 12/08/2023 at 1230 with Nursing Vice President (VP) of ED Services, VPED #20 revealed hospital policy was not followed for Patient #83.

3. Closed medical record review on 11/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 405}	Continued From page 203 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." Patient #43 was assigned to ED Medical Doctor (MD) #23. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4 mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed ". I have ordered IV (intravenous) fluids. 1 mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating). Hospitalist has been consulted for admission. " At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, and thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately). At 1851 the GI Cocktail and Zofran were administered. At 1947 MD #23 ordered Ativan 1 mg IV push NOW (urgent). At 2100 a multivitamin orally was ordered. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT. No medication administrations, IV access/fluids, or physician orders were completed after 1851 (when the GI Cocktail and Zofran was administered) for Patient #43 while in the ED waiting room. At 0105 MD #25 ordered Patient #43 to have Ativan 4 mg IV STAT and was given at 0106 by RN #27. Review of the ER Report	{A 405}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 405}	Continued From page 204 Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. .. " Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841, Ativan IV NOW ordered on 08/14/2023 at 1947, and Phenobarbital STAT ordered on 08/14/2023 at 2305 for Patient #43 were delayed. Interview on 11/15/2023 at 1615 with NP #36 revealed ". it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. " Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room. Interview on 11/16/2023 with ED Internal Processing Area (IPA) Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment. " Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a	{A 405}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 405}	Continued From page 205 reassessment after medication administration. Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI (Emergency Severity Index ESI - score to determine patients with most to least urgent needs), we are not always able to do them. The CNC (Clinical Nurse Coordinator should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments	{A 405}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 405}	Continued From page 206	{A 405}		

to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's providers orders had not been completed.

4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed "...the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed...The Head CT was negative...Once back from CT the patient became profoundly hypotensive and at 1 point lost pulses requiring CPR, total time roughly 5 to 10 minutes...We have been running norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted...." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4 mg in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20 mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 405}	Continued From page 207 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate)...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040..." Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5	{A 405}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 405}	Continued From page 208 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (Physician's Assistant PA #77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 405}	Continued From page 209 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU, a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The	{A 405}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 405}	Continued From page 210	{A 405}		

family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation.

Request to interview ED RN #68 revealed she was not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 405}	Continued From page 211 Request to interview ED RPH #78 revealed she was unavailable for interview. Request to interview ED Manager RN #75 revealed he was unavailable for interview. Request to interview ED Director, RN #76 revealed she was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 405}	Continued From page 212 complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available for this surveyor). Interview on 11/15/2023 at 1637 with VPED #20 revealed hospital policy for Patient #28 was not followed. Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A 405}	Continued From page 213 not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him. Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did. 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 with a pain score of 10 (1 least pain and 10 being the most pain). At 0028 Nurse Practitioner (NP) #39 wrote orders for an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0739 Patient #27 had an IV started of NS	{A 405}		

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{A 405}	Continued From page 214 (7 hours and 11 minutes after ordered), and medications for pain (7 hours and 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed physician orders were not completed in the ED waiting room in 2022. Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed...There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds...things are not happening on a timely basis..." Interview revealed Patient #27 did not get medications as prescribed. Interview revealed hospital policy was not followed for Patient #27. 6. Review on 11/16/2023 of "Nursing	{A 405}		

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{A 405}	Continued From page 215 Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention". Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...". Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review	{A 405}		

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{A 405}	Continued From page 216 revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	{A 405}		
{A 449}	CONTENT OF RECORD CFR(s): 482.24(c) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on review of hospital staff orientation/competency training, medical record review, and staff interviews, hospital staff failed to document baths and/ or linen changes had been	{A 449}	**Subject of Deficiency – A 449** Hospital staff failed to document baths and/ or linen changes had been performed to meet patient activity of daily living needs. **Plan of Correction:** **Education:** Education provided to currently working eligible and targeted staff, including all contract staff, and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.	

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{A 449}	Continued From page 217 performed to meet patient activity of daily living needs in seven (7) of 56 sampled inpatient patient records reviewed (Patient #'s 55, 64, 90, 81, 60, 40, and 26). The findings included: On 12/08/2023 at 0911 review of hospital documentation titled "Preceptor Guide Patient Care Tech (PCT) Staged Orientation" last updated 04/15/2022 revealed the "Preceptor Guide Provides detailed instructions for what the orientee must do for items to be checked off as 'met.'" Further review revealed the orientation stages ranged from 0 through 2. Stage 1 focused on basic patient care and procedures which included documentation. Stage 2 focused on "Routine Application: Provision of Patient Care" which included "Safely and reliably performs routine daily care for a variety of patient populations" and "Anticipates basic potential patient needs." Review revealed in stage 1 of orientation the orientee was expected to meet the following objectives: "Objective that needs to be Met ...Contributes to a healing environment ...Changes linen as indicated (includes occupied / unoccupied bed changes) ..." The orientee expected to meet "Documents activities / care in the EHR (Electronic Health Record) with preceptor assistance" which included "ADL (Activity of Daily Living". Stage 2 for routine application included "providing information related to ADLs and other care to patient ...Prepares in advance to answer questions about topics such as ADLs" Review revealed the skills with "(**)" indicated the skills "are essential items to onboarding and should be completed with orientee to successfully prepare them in patient care." Further review revealed the orientee	{A 449}	• Inpatient RN, LPN and PCT staff (excluding NICU and procedural areas) remedial education on activities of daily living (ADLs) expectations and documentation. **Actions:** • Developed daily report to drive compliance with documentation of ADLs. **Monitoring for Compliance:** The department nursing leader will audit for compliance with hygiene documentation. • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant audits Denominator = 30 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) • **Owner:** Chief Nursing Officer/ACNO	

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{A 449}	Continued From page 218	{A 449}		

assisted with ADLs which included "Hygiene Care** ...Bed bath, Shower and linen change."

On 12/08/2023 at 0911 review of hospital documentation titled "Preceptor Guide Medical Surgical RN Staged Orientation" last updated 04/15/2022 revealed the staged orientation grid was divided into stages 0 through 4. Stage 4 "Preceptor Guide Provides detailed instruction for what the orientee must do for items to be checked off as 'met'" Further review revealed in the "Stage 1 - SKILL BUILDING" the preceptor was to "show" the orientee "how to document routine Activities of Daily Living (ADLs) in the EHR."

On 12/08/2023 at 0911 review of hospital documentation titled "New Employee Orientation" module revealed "Cerner (hospital electronic system) Training for the PCT included "Documenting ADL's"

1. Closed medical record review on 12/05/2023 for Patient #55 revealed on 05/17/2023 at 1638 a 74 year old male arrived in the ED with SOB (shortness of breath). The admission H&P dated 05/17/2023 at 2100 by NP #29 revealed Patient #55 was seen earlier the same day at an outside hospital. The H&P included sarcoidosis diagnosed two years ago and during the last 3-4 days Patient #55 experienced a productive cough with increased SOB. The patient was transferred from the ED to a Medical Surgical Unit room 445 and remained assigned to the room until discharge on 06/06/2023 at 1115. Review revealed there was no documentation that Patient #55 was provided, offered or refused a bath for 16 days or that Patient #55 was provided, offered or refused linen changes x 14 days.

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 449}	Continued From page 219	{A 449}		

On 12/05/2023 request made to interview CNA that provided care for Patient #55. On 12/06/2023 at 1115 it was revealed the CNA was not available.

Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff was expected "to document" performed ADLs.

Interview on 12/08/2023 at 1403 with (Certified Nurse Aide) CNA #33 revealed she offered baths every day and as needed. She stated "especially" if the patient was able to take a shower. CNA #33 revealed she charted when the task was done.

Interview on 12/08/23 at 1448 with CNA #34 revealed patient baths can be given day or night shift. She revealed she checked the chart at the beginning of her day shift to see the number of patients that needed baths. Interview revealed that CNA #34 documented baths right away once done but if she did not have time, she would write the task down on paper and document the task later.

Interview on 12/08/2023 at 0911 with the Director of Clinical Education (DCE) #36 revealed PCT was the same as CNA. She revealed there was not a policy regarding when baths or a change of linen was offered. She revealed that upon hire PCTs were oriented by preceptors which included baths, linen change and documentation once the task was completed. The orientation continued on the assigned unit and a face-to-face with the hospital EMR (Electronic Medical Record)

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{A 449}	Continued From page 220 system. DCE #36 stated "the annual competencies may not be the same for each unit because it depends on the needs of that unit." 2. Closed medical record review on 12/06/2023 for Patient #64 revealed on 08/30/22 at 1547 a 36 year old male arrived in the ED with upper back pain. Review of a progress note dated 08/31/2023 at 1240 by PA #31 revealed per a Radiologist Patient #64 had osteomyelitis to C6-C7 with discitis (inflammation to the disc between the spinal vertebrae - bones). An epidural abscess was present with spinal cord compression that extended from CT to T1 (pressure to the top of the neck-cervical segment to the thoracic segment - chest portion of the spinal cord). A neurosurgery consultation was made for likely urgent surgical intervention. Further review revealed on 08/31/2022 Patient #64 had an emergency "Anterior Cervical Discectomy" spinal surgical procedure. Review of a progress note dated 12/12/2022 at 1419 by an ID (infectious disease) MD revealed Patient #64 remained "profoundly debilitated and with neurologic deficits; he is currently paraplegic but also has upper extremity strength issues." Patient # 64 was assigned to the Pulmonary unit Date: 10/09-15/2022. Review revealed there was no documentation the patient was offered or refused linen changes x 6 days. Patient #64 was assigned to the K-Spine unit, Date: 10/19-26/2022. Review revealed there was no documentation that Patient #64 was provided, offered or refused a bath x 6 days or that Patient #64 was provide, offered or refused a linen change x 5 days for sample week. Patient #64 was assigned to a Med Surg/Telemetry unit, Date: (11/13-19/2022) and (12/25-31/2023) and the patient required total assistance. Review revealed there was no	{A 449}		

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	340002	A. BUILDING _______ B. WING _______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 449}	Continued From page 221 documentation that Patient #64 was provided, offered, or refused baths x 6 days or was provided, offered or refused a linen change x 4 days for the first sample week. Review revealed there was no documentation that Patient #64 was provided, offered or refused baths x 5 days or was provided, offered or refused linen change x seven days for the second week. Patient #64 was assigned to the Neuro unit, Room A611, Dates: 01/06-31/2023 and 02/19-25/2023. Review revealed there was no documentation that Patient #64 was provided, offered or refused a bath x 23 days or provided, offered or refused linen changes x 5 days for the first sample week. Review revealed there was no documentation that Patient #64 was provided, offered or refused baths x 5 days or provided, offered or refused linen changes for the second sample week. Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff was expected "to document" performed ADLs. Interview on 12/08/2023 at 1403 with (Certified Nurse Aide) CNA #33 revealed she offered baths every day and as needed. She stated "especially" if the patient was able to take a shower. CNA #33 revealed she charted when the task was done. Interview on 12/08/23 at 1448 with CNA #34 revealed patient baths can be given day or night shift. She revealed she checked the chart at the beginning of her day shift to see the number of patients that needed baths. Interview revealed that CNA #34 documented baths right away once done but if she did not have time, she would write	{A 449}		

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{A 449}	Continued From page 222 the task down on paper and document the task later. Interview on 12/08/2023 at 0911 with the Director of Clinical Education (DCE) #36 revealed PCT was the same as CNA. She revealed there was not a policy regarding when baths or a change of linen was offered. She revealed that upon hire PCTs were oriented by preceptors which included baths, linen change and documentation once the task was completed. The orientation continued on the assigned unit and a face-to-face with the hospital EMR (Electronic Medical Record) system. DCE #36 stated "the annual competencies may not be the same for each unit because it depends on the needs of that unit." 3. Review of closed medical record revealed Patient #90, a 57 year old female arrived to the hospital on 07/05/2022 for a scheduled surgical total hip arthroplasty (total hip surgical replacement) for continued failed treatment for hip osteoarthritis (degeneration of cartilage and the underlying bone). Review of physician post-surgical orders revealed Patient #90 could shower after surgery. Review of documentation of baths revealed Patient #90 did not receive a bath or shower on 07/06/2022, 07/07/2022, 07/08/2022, 07/09/2022, 07/10/2022, and 07/11/2022, a total of 6 days. Patient #90 was discharged on 07/13/2022. Interview on 12/06/2023 at 1320 with Nurse Manager (NM) #32 revealed staff were expected to offer baths every twenty-four hours, per patient's request and as needed. Interview revealed staff were expected "to document" performed ADLs (activities of daily living--baths or showers).	{A 449}		

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{A 449}	Continued From page 223 4. Closed medical record review revealed Patient #81 was admitted on 09/20/2023 at 1445 with a presenting chief complaint of shortness of breath. Review of the Nursing Flowsheet, revealed on 09/20/2023 no evidence of assistance with activities of daily living on the Medical Cardiology Stepdown unit when patient arrived onto the unit at 2144. On 09/21/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/22/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/23/2023 review failed to reveal evidence of a bath offer/decline or linens changed. On 09/24/2023, 0700 through 1900 (12 hours), RN #4 provided primary nursing care to Patient #81, which failed to reveal evidence of a bath offer/decline or linens changed. On 09/26/2023 review failed to reveal evidence of a bath offer/decline or linens changed. Patient #81 was discharged on 09/26/2023 at 0759 to the skilled nursing facility. Interview with an RN #82 on 12/05/2023 at 1115 revealed, it was the expectation of the facility staff to document that patients were offered or declined daily hygiene opportunities and linen changes in the medical record every 24 hours. Interview with RN #4 on 12/07/2023 at 0955 revealed, it was the expectation of the facility staff that patients were to be offered and documented daily hygiene opportunities and linen changes in the medical record every 24 hours. Interview revealed it was the Registered Nurse to oversee the completion of the task of bathing opportunities, linens changed as part of activities of daily living.	{A 449}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 449}	Continued From page 224	{A 449}		

Continued From page 224

5. Review on 11/28/2023 of the closed medical record for Patient #60 revealed a 63-year-old female that presented to the Emergency Department on 10/31/2022 at 1101 with a chief complaint of chest pain. Patient #60 was admitted to inpatient services on 10/31/2022 at 1646 and discharged on 11/18/2022 at 1556. Review of the nursing notes from 10/31/2022 through 11/18/2022 revealed that Patient #60 was assisted with a bath on 11/03/2022, refused bath on 11/04/2022 and 11/15/2022, basin wipes bath on 11/16/2022 and performed bath independently on 11/17/2022. Documentation failed to reveal evidence that Patient #60 received a bath on 11/01, 11/02, 11/05, 11/06, 11/07, 11/08, 11/09, 11/10, 11/11, 11/12, 11/13, 11/14 and 11/18/2022 (13 of 18 days with no documented bath).

Interview on 12/01/2023 at 0945 with NM #85 and NM #86 revealed the staff were expected to document that patients were offered or refused a daily bath in the medical record every 24 hours.

6. Closed medical record review on 11/14/23 for Patient #40 revealed on 3/4/2023 at 1747 an 84 year old male with a history of Alzheimer's presented with increasing weakness and confusion. Patient #40 remained in the Emergency Department (ED) until being admitted from 3/5/23 at 0216 until discharge to a nursing facility on 3/8/23 at 1722. There was no documentation to reflect an offer/decline of a bath during this 4-day time period.

Closed medical record review on 11/14/23 for Patient #40 revealed on 4/28/23 at 0226 the 84-year-old male with a history of Alzheimer's was transported to the ED via ambulance after falling at a local pharmacy. Patient #40 was diagnosed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
{A 449}	Continued From page 225 with COVID requiring supplemental oxygen then admitted to the facility on 4/29/23 at 0709. Patient #40 remained in the facility until discharge to a nursing facility on 5/9/23 at 1021. There was no documentation to reflect an offer/decline of a bath for the 11-day admission. During the same 11-day admission, there were no documented linen changes with the exception of "no" being documented on 5/5/23 at 0442 and 2000. Interview with RN #81 on 11/14/23 at 1200 confirmed the expectation for nursing to offer and document bathing and linen changes in the medical record. 7. Review on 11/16/2023 of the "Staffing Responsibilities and Procedure" policy revised 02/10/2015 revealed, "Policy: Mission Hospital will maintain staffing to meet patient care needs on all nursing units...". Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review revealed the patient was transferred from the ED to unit B3-South (3rd floor holding area) on 09/02/2022 at 1915. Review of closed medical record lacked nursing documentation related to patient assistance with toileting while located on unit B3-South from 09/02/2022 through 09/03/2022. Review revealed the patient was transferred from unit B3-South to unit A5-West room #566 on 09/03/2022 at 1357. Review of closed medical record lacked nursing documentation related to patient assistance with bathing (shower/bath) and	{A 449}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 449}

Continued From page 226

hygiene needs from 09/03/2022 through 09/07/2022.

Interview on 11/14/2023 at 1545 with RN #101 revealed unit B3-South (3rd floor holding area) is currently not being utilized as a patient care unit. RN #98 revealed during Patient #26's hospital admission starting on 09/02/2022, unit B3-South was a "holding unit" for patients between the ED and admission to an inpatient bed. RN #98 revealed patient rooms on the unit did not have bathrooms in the rooms and patients would have to walk to a bathroom located in the hallway. RN #98 revealed nursing staff should have assisted patients with toileting and/or ambulating to the hallway bathroom.

Interview on 11/16/2023 at 1130 with PCT #99 (Patient Care Technician) while on tour of unit A5-West indicated that he/she assists patients with ADL's (Activities of Daily Living) such as bathing, toileting, and oral care. PCT #99 stated that patients located in even room numbers are assisted with bathing on the dayshift and patients located in odd room numbers are assisted with bathing on the nightshift. PCT #99 stated the unit is often staffed with 1 PCT for up to 36 patients making it difficult to provide care in a safe and timely manner to all patients.

Interview on 11/16/2023 at 1200 with RN #97 (Director) indicated unit A5-West has 36 patient beds which ideally was staffed with 7 RN's, 2 PCT's and 1 unit clerk. RN #97 revealed fully staffing the unit was often a challenge.

{A 576} LABORATORY SERVICES
CFR(s): 482.27

{A 449}

Subject of Deficiency – A 576
The hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department.

Plan of Correction:

Education:

- ED Staff were educated on laboratory Turn Around Time (TAT) collection time goals — 2/6/24
- Laboratory staff education on new analyzer functionality to increase automation — 2/16/24

Actions:

- Reviewed and implemented phlebotomy staffing needs during surge times in ED — 12/2/23
- ED CNC/ED Leadership oversight of lab collection times and escalation via internal communication tool — 12/2/23
- Expansion of Laboratory space to improve automation of services to decrease delays in turnaround times — 2/6/24
- Reviewed new area plan to create efficiencies in workflow by positioning techs around the analyzers, allowing techs to communicate timely and work together to complete tasks faster and reduce TATs — 2/6/24
- Adding new analyzer functionality to all analyzers that will increase automation and lower TATs — 2/16/24

Monitoring for Compliance:
Monitoring and tracking of specimens received to verify timeliness per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits Denominator = 70 audits/month
- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Operating Officer/COO

{A 576}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 576}	Continued From page 227 The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all laboratory services provided to its patients are performed in a facility certified in accordance with Part 493 of this chapter. This CONDITION is not met as evidenced by: Based on policy review, medical record reviews, and staff interviews the hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department (ED) (Patient #'s 83, 27 and 2) and failed to ensure laboratory results were timely for three (3) of three (3) patients (Patient #'s 11, 93, and 94). The findings included: The hospital failed to have available laboratory services to meet the identified turn around times for STAT results for three (3) of 35 patients presenting to the hospital's emergency department (Patient #'s 83, 27, and 2), and failed to ensure timely laboratory results for three (3) of 3 patients that had lab specimens sent to Hospital A's lab from Hospital B (Patient #'s 11, 93 and 94). Cross refer to §482.27 Laboratory Services Standard: Tag A 0583.	{A 576}	Monitoring and tracking of ED laboratory order to collect times through retrospective chart review • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant audits Denominator = 70 audits/month • Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) **Owner:** Chief Nursing Officer/ACNO **Subject of Deficiency – A 583** The hospital failed to have available, adequate laboratory services to meet the needs of patients for three (3) of 35 patients presenting to the hospital's Emergency Department. Each individual Condition of Participation plan of correction for the cross-referenced tag in this section are outlined below.	
{A 583}	EMERGENCY LABORATORY SERVICES CFR(s): 482.27(a)(1) Emergency laboratory services must be available 24 hours a day.	{A 583}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 583}

Continued From page 228

This STANDARD is not met as evidenced by:
Based on policy review, medical record review, incident report review, laboratory logs, documents and staff interview, the hospital failed to have available laboratory services to meet the identified turn around times for STAT (immediate) results for three (3) of 35 patients presenting to the hospital's Emergency Department (ED) (Patient #'s 83, 27, and 2), and failed to ensure timely laboratory results for three (3) of three (3) patients that had lab specimens sent to Hospital A's lab from Hospital B (Patient #'s 11, 93 and 94).

The findings included:

A. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021 revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to

{A 583}

Plan of Correction:
Education:

- ED Staff were educated on laboratory Turn Around Time (TAT) collection time goals

Laboratory staff education on new analyzer functionality to increase automation

Actions:

- Reviewed and implemented phlebotomy staffing needs during surge times in ED
- ED CNC/ED Leadership oversight of lab collection times and escalation via internal communication tool
- Expansion of Laboratory space to improve automation of services to decrease delays in turnaround times
- Reviewed new area plan to create efficiencies in workflow by positioning techs around the analyzers, allowing techs to communicate timely and work together to complete tasks faster and reduce TATs
- Added new analyzer functionality to all analyzers that will increase automation and lower TATs

Monitoring for Compliance:
Monitoring and tracking of specimens received to verify timeliness per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 70 audits/month
- Results reported through Laboratory Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Owner: Chief Operating Officer/VP Operations
Monitoring and tracking of ED laboratory order to collect times through retrospective chart review

- Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant audits
  Denominator = 70 audits/month
- Results reported through Laboratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 583}	Continued From page 229 meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. " 1. Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) with dizziness on 11/28/2023 at 1216. The patient had STAT lab work ordered at 1218. Labs were drawn at 1358. Labs arrived at the lab at 1412 and resulted at 1532 (1 hour and 20 minutes after arriving to lab, 3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. At 0529 the original lactic acid NOW, order was canceled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.	{A 583}	Services Meeting, ED Steering Committee, Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) **Owner:** Chief Nursing Officer/ACNO	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A 583}	Continued From page 230	{A 583}		

Review of Patient Safety Analysis completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this (within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work.

Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed.

Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have trouble getting in contact with the phlebotomist. That morning they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 583}	Continued From page 231	{A 583}		

were not logged into to their IMobile device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy.

Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for Patient #83.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 583}	Continued From page 232	{A 583}		

2. Closed medical record review revealed Patient #27 arrived in the ED on 07/04/2022 at 0025 with abdominal pain reported as a pain level of 10 of 10. Orders for STAT lab work were placed at 0028. Lab results were completed at 0734 (7 hours and 6 minutes after ordered). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work.

Interview on 11/15/2023 at 1350 with ED Registered Nurse (RN) #38 who triaged Patient #27 revealed "... It's very possible that this patient waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed physician orders were not completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED Medical Doctor (MD) #26 revealed "...I saw the patient after she was roomed. ... There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. ... things are not happening on a timely basis. " Interview revealed hospital policy was not followed for Patient #27.

3. Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent".

Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed "...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A 583}	Continued From page 233	{A 583}		

66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. ED record review revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified. Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed ". the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order. "

Interview on 12/09/2023 at 1159 with Lab Director #18 revealed ". The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be

{A 583} Continued From page 234
completed within an hour..."

B. Review of policy Microbiology Turn Around Times, Effective 05/30/2023, revealed "...III. POLICY A. Microbiology services are available 24/7. B. Specimens are received and processed on all 3 shifts. Microbiology Department: Test menu and turnaround time information. 17. Urine Culture a. Negative Culture: i. Non-invasive (i.e. clean catch & indwelling cath): 18-24 hours ii. Invasive: 48 hours b. Positive Culture: 24-48 hours ... "

Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #11 revealed that a urine culture was submitted on 09/14/2023. The positive results were released on 09/19/2023 (four days after the specimen was received in the lab).

Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #94 revealed that a urine culture was submitted on 09/06/2023. The positive results were released on 09/12/2023 (six days after the specimen was received in the lab).

Review on 11/15/2023 of lab work sent to Hospital A from Hospital B as an outpatient lab service for Patient #93 revealed that a urine culture was submitted on 09/18/2023. The positive results were released 09/23/2023 (five days after the specimen was received in the lab).

Review on 11/16/2023 of a log of all urine cultures processed by the Microbiology section from 09/23/2023 through 09/30/2023 revealed that 14 of 29 cultures, or 48%, were resulted at greater

{A 583}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A 583}	Continued From page 235	{A 583}		

than 48 hours.

Review of an email from a Laboratory Microbiology Manager on 11/15/2023 at 1121 revealed "...There were delays in getting these finalized due to critical staffing in Microbiology . The decision was made on 09/19/2023 to start sending all of (named Hospital) to (Named outpatient Laboratory Company) since we didn't have the staff to read all cultures. The staff had to prioritize cultures. Outpatients were not looked at on a daily basis. They had to prioritize inpatients and critical specimen types such as blood cultures. However, they did sub the organisms each day to make sure they were viable to do identification and susceptibility testing."

Request for interview with the Laboratory Microbiology Manager revealed they were unavailable.

Telephone interview on 11/17/2023 at 0959 with the North Carolina Division Director of Laboratory revealed that during September 2023, the hospital microbiology department was experiencing critical staffing problems due to vacancies and staff on medical leave. The Director stated that on 10/02/2023, it was decided to use an outside Laboratory company to handle microbiology cultures. The Director also stated that at the same time, the department focused on staffing, hiring travelers and training on new processes. The Director stated that on November 6th, 2023, the hospital inpatient cultures were returned to in-house processing. The Director stated the Quality dashboards were being created to monitor turnaround times for cultures going forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A1100}	Continued From page 236	{A1100}		
{A1100}	EMERGENCY SERVICES CFR(s): 482.55 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on policy review, medical record review, incident report review, Emergency Medical Services (EMS) trip report review, and staff and provider interviews, the hospital staff failed to have effective emergency services to meet the needs of patients that presented to the Emergency Department. The findings included: Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patient upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26). Cross refer to §482.55 Emergency Services Standard: Tag 1101.	{A1100}	**Subject of Deficiency: A 1100** The hospital staff failed to have effective emergency services to meet the needs of patients that presented to the Emergency Department. **Subject of Deficiency: A 1101** Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including laboratory, telemetry and medication orders.	
{A1101}	ORGANIZATION AND DIRECTION CFR(s): 482.55(a) Organization and Direction. If emergency services are provided at the hospital --	{A1101}		

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{A1101}	Continued From page 237	{A1101}		

This STANDARD is not met as evidenced by:
Based on policy review, medical record review, incident report review, EMS trip report review, and staff and provider interviews, Emergency Department (ED) nursing staff failed to ensure emergency care and services were provided according to policy and provider orders by failing to accept patients upon arrival to the ED, evaluate, monitor and provide treatment to emergency department patients to prevent delays and/or lack of triage, nursing assessment, and implementation of orders, including lab, telemetry and medication orders for eleven (11) of 35 patient records reviewed (Patient #'s 92, 83, 43, 28, 27, 29, 6, 1, 2, 12 and 26).

The findings included:

Review on 12/06/2023 of the hospital policy "Triage - Emergency Department 1PC.ED.0401" revised 07/2023 revealed, "...DEFINITIONS: ... A. Triage Assessment: The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified RN (Registered Nurse) at the time of presentation and before registration. This is a focused assessment based on the patient's chief complaint and consists of information, which is obtained that would enable the Triage RN to determine minimal acuity. A rapid or comprehensive triage assessment is completed, with a goal of 10 minutes, on arrival to the emergency department. 1. A rapid triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. 2. A comprehensive assessment,

Plan of Correction:
Immediate Actions Taken
Upon receipt of the recommendation of Immediate Jeopardy by the onsite surveyors under the Conditions of Participation (COP) of Emergency Services, Patient Rights, and Nursing Services on 12/1 the following actions were taken to mitigate the findings:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Arrival to triage – implementation of time stamp process to capture accurate arrival times including rapid triage process
  - 12/1/23 Education - Staff were educated that patients arriving to the ED need to be seen and care promptly assumed with a goal of 10 minutes upon arrival. — 12/1/23
  - 12/1/23 Timestamp implementation process - Education for staff regarding process for accurately reflecting patient time of arrival to time of triage — 12/1/23
  - 12/1/2023 Triage line of >3 patients prompt escalation pathway for additional support — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication involving ED CNC/ED leadership oversight to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool. — 12/2/23
- Arrival to EKG-10 min
  - 12/1/2023 Staff education with attestation — 12/1/23
  - 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding EKG orders involving ED CNC/ED leadership oversight. — 12/2/23

Post Medication Administration Assessment Completed as indicated

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101}	Continued From page 238 performed on each patient that presents to the emergency department, is a focused physical assessment including vital signs, pain scale, allergy, history of current complaint, current medications, exposure to infectious disease, and pertinent past medical/surgical history. .... B. Triage Acuity Level - The Emergency Severity Index (ESI) is a five level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. C. Reassessment - A process of periodic re-evaluation of the patient's condition and symptoms prior to and during the initiation of treatment. Reassessment components may include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Reassessment after the medical screening exam are performed by RN's (Registered Nurses) according to acuity or change in patient's condition. D. Vital Signs - Helps nursing personnel determine the stability of patients and acuity of those that are that are presenting with life-threatening situations or who are in high-risk categories. Usually refers to temperature, pulse rate, respiratory rate, and blood pressure. May include pulse oximetry for patients presenting with respiratory and/or hemodynamic compromise, and pain scale for those patients with pain as a component to their presenting complaint...PROCEDURE: ... B. All patients presenting for care will be evaluated by an RN. This RN should complete a brief evaluation of the patient, including immediate compromise to a patient's airway, breathing, or circulation..... H. If there is no bed available, the patient will need to wait in the lobby. While in the	{A1101}	o 12/2/2023 Staff education with attestation o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding pain reassessment post medication administration involving ED CNC/ED leadership oversight. • Order to lab draw-30 minutes o 12/2/2023 Timely and frequent real-time structured communication regarding review and escalation of outstanding order to lab collection involving ED CNC/ED leadership oversight. • Provider response to emergent needs when escalated o 12/2/2023 Letter sent from CMO and Chief of Staff to all hospital-based providers who render care in the ED • Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool. o 12/2/2023 CNO and VP Emergency Services meeting to level set on CNC expectations • ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons o 12/2/2023 EKG icon education boost o 12/21/2023 Stethoscope icon o 12/26/2023 Telemetry • 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access, performance improvement, to develop a process to off-load EMS • 12/7/23 Deployed inpatient tech to assist Emergency Department Staff with vital sign reassessments in the Internal Processing Area (IPA). (This measure was in place through the implementation of the front-end redesign). • 12/6/2023 Multi-disciplinary team with ER staff, facility executives, CSG, patient access	12/2/23 12/2/23 12/2/23 12/2/23 12/2/23 12/2/23 12/21/23 12/21/23 12/6/23 12/7/23 12/6/23

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{A1101}

Continued From page 239

lobby, patient reassessment and vital signs should be documented in the health record in accordance with documentation guidelines. ....."

Review on 12/09/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed, "... PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible ... The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing and evaluating patient care or treatment. .... DEFINITIONS: A. Assessment: The multidisciplinary assessment process for each patient begins at the point where the patient enters a (facility name) facility for care, and in response to changes in the patient's condition. ....The assessment will include systematic collection and review of patient-specific data necessary to determine patient care and treatment needs. B. Reassessment: The reassessment process is ongoing and is also performed when there is a significant change in the patient's condition or diagnosis and in response to care. .... SECTION VI: EMERGENCY DEPARTMENT: A. Patients should be triaged following guidelines set forth in the system Triage Policy (1PC.ED.0401), including documentation of required elements within the electronic medical record (e.g. Vital signs, Glasgow Coma Scale (GCS)). B. The priority of data is determined by the patient's immediate condition. On arrival to unit, an initial assessment is initiated and immediate life-threatening needs are determined with appropriate interventions implemented. C. Patient assessment should be performed based on the developmental, psychosocial, physiological, and age-specific needs of the

{A1101}

performance improvement, to develop a process to off-load EMS

- 12/14/2023 Instituted rapid triage process — 12/14/23
- 12/14/2023 Provider alterations in workflows including the printing of discharge instructions to decrease patient disposition to depart metric and improve throughput. — 12/14/23
- 12/9/2024 Trial EMS off-load location set-up — 12/9/23
- 12/12/23 Explored alternate inpatient treatment locations to increase inpatient capacity and decrease ED holds. This resulted in halting the remodel of A3 West (38 beds) inpatient unit and the area was prepared for reopening. This allows for increased inpatient capacity, decreased number of emergency department holds, which reduced ED volume and allows ED staff to be free to care for ED patients. D2 (20 beds) was identified as an additional overflow treatment area. These areas are staffed with acute care inpatient nurses — 12/12/23
- 12/13/2023 Trial EMS off-load process — 12/13/23
- 12/14/2023 Tracking and trending of implementation of EKG orders — 12/14/23
- 12/20/2023 ED CMU escalation pathway education and implementation — 12/20/23
- 12/29/23 A3W unit (38 beds) opened to increase inpatient capacity, reduce the overall inpatients being held in the Emergency Department, which reduced ED volume and allows ED staff to be free to care for ED patients. Also, during this time D2 (20 beds) was utilized intermittently as needed in response to increases in inpatient volumes. These areas are staffed with acute care inpatient nurses. — 12/29/23

Ongoing Actions:
Monitoring of patient condition beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding.

- Timely and frequent structured real time communication involving ED CNC/ED Leadership oversight to include: safety, patient throughput, pending medications/reassessments/diagnostics and escalations via internal communication tool.
    - 1/5/2024 direction was given for closed loop communication within 60 minutes of escalated barriers — 1/5/24

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	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

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{A1101}

Continued From page 240

individual. D. Focused patient history and physical assessment are based on patient's presenting problem(s) including individual indicators of vulnerability. E. Reassessment: 1. Reassessment is ongoing and may be triggered by key decision points and at intervals based on the needs of the patients. Additional assessment/reassessment elements and frequency are based upon patient condition or change in condition, diagnosis, and/or patient history, not to exceed four hours. Interventions may warrant more frequent assessments...."

1. Closed medical record review on 12/09/2023 of Patient #92 revealed a 69 year-old male that presented to the emergency department on 11/09/2023 at 1149 via private vehicle with a chief complaint of chest pain. The patient was triaged at 1155 with a chief complaint of "Woken from sleep at 0400 with midsternal chest pain, described as sharp and pressure. No SOB (shortness of breath), arm/jaw/back pain, or diaphoresis (sweating). H/o (history of) colon CA (cancer) with mets (metastasis) to the lung, currently on chemotherapy. .." Review revealed vital signs of blood pressure (BP) 125/60, pulse (P) 57, temperature (T) 97.4 degrees Fahrenheit, oxygen saturation (O2 Sat) 97% and a pain level reported as 2 (scale 1-10 with 10 the worst). Review revealed a triage level of 2 (level 1 most urgent). Review revealed a Medical Screening Examination by a physician was started in the waiting room area at 1209. Review of the physician's notes recorded the patient's chest pain had been waxing and waning, coming in waves and lasting about five minutes at a time. Review revealed a plan to conduct an ED chest pain work-up including a chest x-ray, EKG and labs including CBC, chemistry, lipase and

{A1101}

via internal communication tool

- ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons
    - 2/1/2024 EHR enhancement of visual cue at 30 minutes to prompt staff to better capture post-medication administration assessments — 2/1/24
- 1/20/2024 Meeting between Radiology, ED, and Quality Leadership to review ED current processes and opportunities. Applicable actions taken from that meeting include: — 1/20/24
    - 1/25/2024 Modification of HCG order process to streamline results — 1/25/24
    - 1/30/2024 Structured communication to close loop on identified opportunities for improvement — 1/30/24
    - 1/30/2024 Standardized process to facilitate patient readiness for CT — 1/30/24
- 1/22/2024 Regional EMS Coordinator hired for coordination and communication with EMS — 1/22/24
- 1/26/2024 Process implemented to evaluate ED CMU tech staffing during peak hours — 1/26/24
- 1/30/2024 Escalation of pending CTs via internal communication tool beginning with RN triage, vital signs are obtained by providing qualified personnel for ongoing rounding. — 1/30/24
- 1/30/2024 ED triage process/workflow enhancement launched with ED front end re-design — 1/30/24
    - 1/5/2024 Process in place to evaluate need for additional triage RN during peak hours — 1/5/24
    - 1/5/2024 Developed triggers for triage escalation and posted at triage desk — 1/5/24
    - 1/5/2024 Assessment/Re-assessment policy review — 1/5/24
    - 1/11/2024 Due diligence walk through with ER Operations and IT — 1/11/24
    - 1/11/2024 Front-end multidisciplinary team design session — 1/11/24
    - 1/12/2024 Assessment/Re-assessment policy approved — 1/12/24

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{A1101}	Continued From page 241 troponin, and administer a dose of aspirin. Review recorded a differential diagnosis of GERD (gastroesophageal reflux disease), referred abdominal pain, musculoskeletal chest pain, ACS (acute coronary syndrome), with lower suspicion for PE (pulmonary embolus) given no tachycardia, hypotension, or evidence of DVT (deep vein thrombosis) on exam. Review revealed the ED physician recommended admission for further chest pain workup based on risk factors. Review of physician's orders revealed labs were ordered at 1218, collected at 1320 and resulted at 1332. Review revealed a troponin result of 0.013 (normal). Review revealed a physician's order placed at 1218 for continuous ECG (telemetry) monitoring in the ED. Review of the ED record revealed no evidence that continuous ECG monitoring was initiated in the ED. A chest x-ray was ordered at 1220 and resulted at 1246 with normal results. An EKG was completed at 1224 which showed sinus rhythm with premature atrial complexes (PACs), with no changes when compared with a prior EKG done in 2022 per the physician's read. A troponin resulted at 1320 as 0.013 (normal) and a baby aspirin was administered as ordered at 1334. A second troponin ordered at 1607 and resulted at 1704 as 0.014 (normal). Review of a second EKG completed at 1628 revealed "Sinus rhythm with premature atrial complexes (PACs). Otherwise normal ECG. When compared with ECG of 09-Nov-2023 12:24, Non-specific change in ST segment in inferior leads. ST elevation now present in Lateral leads." Review recorded the ECG was confirmed by a physician on 11/09/2023 at 1821. Review revealed a physician's order at 1659 for nitroglycerine 0.4 milligrams (mg) sublingual every five minutes times three as needed (prn) chest pain. Record review revealed	{A1101}	by CNO and Nursing Operations Council	
			o 1/12/2024 Staff participated in organization and set-up of Critical Supply Room	1/12/24
			o 1/12/2024 Walkthrough with BioMed for wall mounted cardiac monitors	1/12/24
			o 1/13/2024 Mock set-up of room 32	1/13/24
			o 1/15/2024 Addition of script printer in room 115	1/15/24
			o 1/15/2024 IT refresh complete	1/15/24
			o 1/16/2024 MD, Lab operations, IT agreement to new lab order process to expedite results for HCG	1/16/24
			o 1/16/2024 Capital PO issued for 4 portable cardiac monitors	1/16/24
			o 1/16/2024 Added additional monitor to Air Traffic Control (ATC) desk to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals	1/16/24
			o 1/17-29/2024 Reconfigured front-end area	1/29/24
			o 1/17/2024 Per staff request, 3 additional vital sign machines provided	1/17/24
			o 1/17/2024 Front-end multidisciplinary team education and roles and responsibilities review	1/17/24
			o 1/18/2024 Front-end education of ER providers in January provider meeting by ER Medical Director	1/18/24
			o 1/23/2024 Standardization of supply carts	1/23/24
			o 1/18/2024 Confirmed Team Health Leadership participation during 1/30 go- live	1/18/24
			o 1/18/2024 Standardization and escalation of Pharmacy order verification under the MAR education	1/18/24
			o 1/18/2024 Worked with pharmacy to standardize medication storage units	1/18/24

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{A1101} Continued From page 242

no nursing assessment/reassessment documented after the patient's triage was recorded at 1155. The patient was administered Morphine (narcotic pain medication) 2 milligrams intravenously (IV) at 1703 by a medic for a pain level of 4. There was no reassessment of the patient's pain and no documentation of the patient's condition by a nurse. The patient was moved from the waiting room to a bed in the orange pod (admission holding area of the ED) at 1937. Nitroglycerine 0.4 milligrams sublingual was administered by a nurse times one for a pain level of 10 at 2013. Review revealed no reassessment of the patient's response to the medication intervention and no nursing assessment of the patient's condition was documented. The patient was transported from the ED to a medical surgical floor on 11/09/2023 at 2054. The patient was placed on continuous telemetry at 2111 when he was noted to be in Atrial Fibrillation with Rapid Ventricular Rate (abnormal heart rhythm). Review of the ECG completed at 2110 recorded an "ST elevation consider lateral injury or acute infarct ** ** ACUTE MI / STEMI (myocardial infarction or heart attack) ** ** ...". Review of a Cardiovascular Consult History and Physical documented on 11/10/2023 at 0020 as an Addendum revealed the patient "... went into AF/RVR (Atrial Fibrillation with Rapid Ventricular Rate) at 2110 hrs this evening with ECG demonstrating evolving high lateral STEMI (I, aVL) which was more pronounced on follow-up ECG at 2210 hrs prompting formal STEMI activation for emergent cardiac catheterization. ..." Review of a Discharge Summary dated 11/13/2023 at 1211 revealed the patient was discharged home on 11/13/2023 with a diagnosis of STEMI (ST elevation myocardial infarction),

{A1101}

- o 1/18/2024 Added medication refrigerator to the medication storage unit — 1/18/24
- o 1/18/2024 Educate staff on defined roles/responsibilities and standard work flow — 1/18/24
- o 1/19/2024 Designated location for discharge paperwork and standardized process — 1/19/24
- o 1/22/2024 Streamlined laboratory process for COVID, Flu, and RSV to improve timeliness of results — 1/22/24
- o 1/23/2024 Confirmed 100% of providers received education on front-end process re-design — 1/23/24
- o 1/24/2024 Front-end multidisciplinary team Go/No Go meeting with decision to move forward — 1/24/24
- o 1/25/2024 Launch discharge print button to support greater efficiency for the providers to print discharge instructions — 1/25/24
- o 1/26/2024 Greet tracker installed in provider area — 1/26/24
- o 1/26/2024 Streamlined laboratory process to expedite results for HCG — 1/26/24
- o 1/26/2024 6 workstations on wheels (WOW) deployed for provider and CNC documentation efficiency (decreased time from arrival to first clinical order) — 1/26/24
- o 1/29/2024 Increased staff efficiency by stocking blood culture bottles in all areas — 1/29/24
- o 1/30/2024 Created intake teams to perform MSE, nursing documentation, and implement initial interventions in Internal Processing Area (IPA) — 1/30/24
- o 1/30/2024 Deployed 4 portable cardiac monitors — 1/30/24

Education:
Education provided to currently working eligible and targeted staff and providers using multiple mechanisms. These mechanisms included email, HealthStream, huddles, 1:1, and/or flyers used by department leaders and with the assistance of the Center for Clinical Advancement (education). Emergency Department huddles occur at the start of each working shift. Working shift start times include (7am, 9am, 11am, 1pm, 3pm, and 7pm). Shift huddle tactic used to educate 100% of working staff. Staff who have not completed required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during first returned shift.

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{A1101}	Continued From page 243	{A1101}		

Coronary Artery Disease, Hypertension, and Atrial Fibrillation with RVR.

Interview on 12/09/2023 at 1210 with ADON #17 revealed Patient #92 was identified as a level 2 triage and should have been assessed every four hours at a minimum, every two hours for a level two and with any change in the patient's condition. Interview revealed the patient developed chest pain and required interventions and no nursing assessments or reassessments were documented in the ED record. Interview revealed continuous telemetry was ordered for the patient at 1218 and telemetry was not placed on the patient in the ED. Interview revealed the telemetry was placed on the patient at 2111 once the patient transferred to the medical floor.

Patient #92 presented to the ED with chest pain on 11/09/2023 at 1149. The patient was not assessed by a nurse after triage was completed at 1155, or with a change in condition, or after pain medication was administered at 1703. The patient was never placed on continuous telemetry in the ED as ordered by a physician at 1218. The patient was transferred to a medical floor and placed on telemetry at 2111 when he was found to be in atrial fibrillation with rapid ventricular rate, prompting a STEMI Code Activation. The patient underwent an emergency cardiac catheterization at 2249. ED nursing staff failed to provide ongoing assessment of the patient's condition and follow physician's orders for application of continuous telemetry. Nursing staff failed to ensure policies and provider orders were implemented.

2. Review on 11/17/2023 of the hospital policy Turn Around Time, last revised 11/17/2021

Provider's Plan of Correction ({A1101}):

. Education has been incorporated into new hire and contract staff education. Education in the huddle format is used to capture 1:1 dialogue and understanding to include opportunities for teach back and questions.

- 12/2/2023 Education for ED nursing staff regarding process for accurately capturing patient arrival time for both walk in and EMS arrivals — 12/2/24
- 12/2/2023 Education provided to ED CNCs/ED Leadership regarding timely escalations and departmental oversight — 12/2/24
- 12/2/2023 ED nursing staff education regarding timely triage for both walk in and EMS patient arrivals — 12/2/24
- 12/2/2023 ED nursing staff educated regarding EKG completion timely per policy/protocol — 12/2/24
- 12/14/2023 ED nursing staff education with attestation post-opiate medication administration assessment — 12/14/24
- 12/21/2023 ED nursing staff education regarding telemetry order initiation — 12/21/24
- 12/21/2023 ED nursing staff education regarding telemetry initiation escalation process — 12/21/24
- 12/21/2023 Education/resource binder created for ED Central Monitoring Unit (CMU) staff — 12/21/24
- 12/21/2023 ED nursing and ED CMU staff educated regarding CMU escalation pathway — 12/21/24
- 1/15/2024 ED nursing staff focused education on pain assessment/re-assessment, EKG Order to complete, lab order to collect, Arrival to Triage for EMS and Front Entrance Patients (Triage), escalation process, and telemetry cardiac monitoring through 1:1 conversations with nursing staff completed by education team — 1/15/24
- 1/18/2024 All ED staff education (all staff) for front-end redesign, order to collect, arrival to triage, arrival to greet, greet to first order — 1/18/24
- 1/18/2024 Provider education for front- end redesign — 1/18/24
- 2/2/2024 ED nursing staff Clinical Institute Withdrawal Assessment (CIWA) remedial education provided via shift huddles. — 2/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

(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) COMPLETION DATE
{A1101}	Continued From page 244	{A1101}		2/6/24

{A1101} (Summary statement of deficiencies)

revealed "...PURPOSE: To provide timely and efficient testing services for routine, critical and high-risk situations. DEFINITIONS: Turn Around Time (TAT): the time elapsed from order placement to result reporting. Categorized as: Pre-analytical Phase: the period between test order entry by the caregiver and specimen receipt in the Laboratory. May be influenced, but not controlled by the Laboratory. Analytical Phase: the period between specimen receipt in the Laboratory and result reporting. Controlled by the Laboratory...STAT: an emergent, potentially life-threatening request. NOW: as soon as possible. Synonymous with ASAP. POLICY: All tests will be performed without delay to maximize specimen quality and integrity. STAT, NOW ... requests will be managed as priority situations. First-in, First-out (FIFO) processes are utilized to facilitate rapid and efficient movement of specimens through the system. Requests are also prioritized based on the following criteria to meet defined turn-around times: ...Response to STAT requests: ...STATS take priority over other specimens and should be managed from time of receipt until result reporting with no interruption in handling or testing. In general, the maximum TAT for most tests is 45-50 minutes from order receipt. ... Response to NOW/ASAP requests: ...Staff will immediately process the specimen, perform testing, and verify results. Results should be available within (1) one hour from specimen receipt. ... TAT Summary (Inpatient): STAT, Time from ORDER Receipt 45-50 minutes. NOW, Time from SPECIMEN receipt 1 hour. "

Closed medical record review on 12/06/2023 revealed Patient #83, a 74-year-old female patient who arrived at the emergency department (ED) via emergency medical services (EMS) on

{A1101} (Provider's plan of correction) — Completion date: 2/6/24

- 2/6/2024 All ED staff (RNs, PCTs, paramedics, HUCs) education on regarding ligature risk definition and documentation

Monitoring for Compliance/Audit Details: Monitoring and tracking procedures were implemented to ensure that the POC is effective and that the specific deficiency cited remain corrected and in compliance with the regulatory requirements.

Daily monitoring of performance for the following:

- o Arrival to Triage Times for walk-in and EMS
- o Arrival to EKG order-to- complete per policy/protocol
- o Pain Medication assessment/ reassessment per policy/protocol
- o CIWA assessments per policy/protocol
- o Realtime escalation of patient safety concerns
- o CT order to exam

Sustained Compliance Audits to Ensure POC is Effective:

Monitoring and tracking of arrival-to-triage times per policy/protocol (walk in and EMS)

- The goal of our audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be review and remediation specific to outliers for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant arrival-to triage times per policy/protocol
- Denominator = 70 observation per month
- Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

Monitoring and tracking of EKG order-to- completion per policy/protocol

- Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters.
- Numerator = # of compliant EKG order- to-completion per policy/protocol audits Denominator = 70 audits/month
- Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT)

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{A1101}	Continued From page 245 11/28/2023 at 1216 with a chief complaint of dizziness from her doctor's office. Patient #83 was seen by an ED MD #1 on arrival and at 1218 a comprehensive metabolic panel (CMP) [includes serum glucose] was included in laboratory tests ordered as STAT (an emergent, potentially life-threatening request) with continuous ECG monitoring. At 1259 Patient #83 was placed in Red Pod (for the most acute patients) Hallway Bed-17. At 1309 the first set of vital signs was recorded by RN #2 as temperature 98.7, heart rate 84, respirations 19, blood pressure 225/88, and oxygen saturation of 93 percent on room air. At 1316 RN #3 completed a nursing triage assessment and Patient #83 was given an emergency severity index (ESI) [level 1 as the most urgent and 5 as the least urgent] of 3-urgent. Review of the CMP history revealed the STAT lab was collected at 1358 by RN #3 (1 hour and 40 minutes after the order was placed), the blood specimen arrived at the laboratory at 1412, and resulted at 1532 (3 hours and 14 minutes after the STAT order was placed) with a serum glucose resulted of 1137 (high normal range 120). Review of the Physician's Order on 11/28/2023 at 1626 by ED Nurse Practitioner (NP) #5 revealed a new order for an Insulin (IV medication to reduce serum glucose) IV infusion to be started (54 minutes after the glucose had resulted). At 1709 an Insulin drip was initiated for Patient #83 by the RN #3. At 1739, the Hospitalist NP #6 placed a continuous telemetry monitoring order for 48 hours for Patient #83, with vital signs every 2 hours while in the ED. At 1908 ED MD #14 ordered a Glycosylated Hemoglobin NOW that was collected at 2128 (2 hours after ordered). At 2109 Patient #83 was moved to the ED Holding-Orange Pod-Room-2 awaiting an	{A1101}	Monitoring of new orders for continuous ECG monitoring and timely initiation of monitoring per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process sustained for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant ECG monitoring and timely initiation of monitoring per policy/ protocol audits Denominator = 70 audits/month • Results will be reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of pain medication assessment/reassessment per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant pain medication assessment/reassessment per policy/protocol audits Denominator = 70 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Monitoring of CIWA assessments per policy/protocol • Goal of 90% compliance with 100% remediation of outliers/deviation from process for 3 months, with quarterly monitoring for subsequent 4 quarters. • Numerator = # of compliant CIWA assessments per policy/protocol audits Denominator = 30 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Review of facility patient safety concerns by Hospital Leadership and members of the Quality/Patient Safety/Risk team • Facilitation of early event identification for timely investigation/action as appropriate • Monitor for trends • Ensures routing of events to appropriate parties for review	

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{A1101}	Continued From page 246 inpatient bed. At 2329 Hospitalist MD #9 ordered an IV infusion of D51/2 NS with KCL (Dextrose, Normal Saline, and Potassium Chloride Solution). On 11/29/2023 at 0127 MD #9 ordered a Lactic Acid (carries oxygen from your blood to other parts of your body) level to be drawn "NOW" for "nurse collect" for Patient #83. At 0153 MD #9 ordered to suspend the insulin IV. An addendum was made to the History and Physical at approximately 0200 by MD #9 which revealed "...Unfortunately patient has been on insulin drip since 5pm without continuous fluid administration or repeat blood work, it is currently 2 am, Nursing staff was previously contacted requesting these , later on did let provider know there was difficulty obtaining blood work as well as delay in obtaining D51/2NS KCL fluid from pharmacy. Given we have no blood work, no fluids, for the safety of the patient will suspend insulin drip at this time, until blood work is back to ensure appropriateness of insulin drip infusion..." 0157 RN #10 documented the IV with D51/2NS KCL as started (2 hours and 27 minutes after ordered). At 0200 Patient #83's Insulin IV was suspended by RN #10. At 0256 Patient #83's Insulin IV was reordered and was resumed (56 minutes after it was stopped). On 11/29/2023 at 0514 Patient #83 was transported to a Stepdown Unit. Review of the ED record revealed no evidence that continuous telemetry monitoring or vital signs every 2 hours were initiated in the ED by a nurse, further the NOW Lactic Acid "nurse collect" order at 0127 was never drawn while the patient was in the ED. On the inpatient floor, at 0529, RN #11 cancelled the 0127 NOW Lactic Acid order "nurse collect" from the ED and reordered the NOW Lactic Acid order "lab collect". The Glycosylated Hemoglobin NOW that was ordered 11/28/2023 at 1908 resulted on 11/29/2023 at 0743 (12 hours and 35 minutes	{A1101}	• Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) Process improvement initiative – Tracking ED CT order-to-exam average time and trending outliers • Escalation of pending CTs via internal communication tool. Outliers are reviewed by interdisciplinary team • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT) **Owner:** Chief Nursing Officer/ACNO/VP Emergency Services	

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{A1101}	Continued From page 247 after ordered) with result of 12.3 (normal high range 6.3). At 0844 the Lactic Acid was drawn (3 hours and 15 minutes after it was ordered), was in the lab for processing at 0907, and resulted at 1108 (5 hours and 39 minutes after ordered) as "7.48" (high normal for lactic acid was 2.1). The computer system automatically reordered an additional Lactic Acid order by default and was collected at 1119 and was in the lab to be processed at 1148. At 1146 RN #12 documented a blood pressure of 141/67 with respirations of 36. At 1158 Rapid Response was called for Patient #83. At 1206 blood pressure was 65/40. At 1213 blood pressure was recorded at 68/40. At 1225 a Levophed (medication used to increase blood pressure) IV infusion was initiated via interosseous to increase her blood pressure. At 1245 the blood pressure was 126/84 at 98 percent oxygen saturation while the patient was being mechanically bagged at the bedside. At 1247 Patient #83 was intubated (mechanical ventilation), at 1250 Patient #83 was transferred to the medical intensive care unit. At 1256 the second Lactic Acid resulted as critically high "11.96". After discussion with the family, Hospitalist MD #16 changed Patient #83 Full Resuscitation status to Limited Resuscitation with no cardiopulmonary resuscitation (CPR). Patient #83 expired on 11/30/2023 at 1337. Review on 12/06/2023 of a Patient Safety Analysis (Incident Report) completed by RN #12 on 12/01/2023 at 1917 revealed this Care Event was a "Delay in Care" and the issue was "Lack of timely response to Order", for Patient #83. A description "A NOW LA (lactic acid) order was placed at 0529. Lab wasn't drawn until 0844, and in lab at 0907. Critical results of lactic acid 7.48 reported at 1108. MD at 1114...Shortly after this	{A1101}		

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{A1101}	Continued From page 248	{A1101}		

Continued From page 248

(within the hour), the patient took a turn and had to be intubated at bedside and sent to ICU (intensive care unit) ...Solution to Prevent this from Recurring? Promptly follow orders..." This Patient Safety Report was still in process. Review of the report revealed Patient #83 had a delay in lab work.

Request to interview MD #9 revealed she was unavailable for interview.

Request to interview MD #16 revealed he was unavailable for interview.

Telephone interview on 12/07/2023 at 1632 with RN #10 who cared for Patient #83 in the Orange Pod (location in the ED for pending admissions) revealed "...I work on an inpatient unit and was pulled to the ED that day. It's a revolving door, I don't recall this patient in particular. If I can't get the labs, I would call a phlebotomist after 3 tries to get the labs if I couldn't..." Interview revealed she could not remember why the NOW lactic acid order was not collected. Interview revealed physician orders for Patient #83 were not followed.

Interview on 12/08/2023 at 0915 with RN #11 revealed she did remember Patient #83 and worked night shift. "...I did not receive a report on this patient from the ED. You have to look up the medical record number and sometimes the charge nurse gets an alert that the patient is coming and will print the face sheet. I had to piece it together and go through the orders. I reordered the lab work when I saw it was pending. My concern is we have had trouble getting in contact with the phlebotomist. That morning they were not logged into to their imobile

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{A1101}	Continued From page 249	{A1101}		

device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me 'we don't have another option right now.' I can't recall if she was on a telemetry box or not, I was only with her over an hour..." Interview revealed not being able to reach a phlebotomist during night shift had happened before. Interview revealed RN #11 had called multiple times to reach the lab phlebotomist to draw NOW blood orders without reaching someone. Interview revealed lab Turn Around Time for NOW lab orders was not followed for Patient #83.

Interview on 12/08/2023 at 1309 with Laboratory Phlebotomist Supervisor #17 revealed "...the phlebotomists do not collect in the ED; we will help if called. All labs ordered in the ED default to "nurse collect". The expectation was for STAT and NOW orders to be from order to collection in 15 minutes and to be resulted in an hour from order..." Interview revealed lab collection for STAT and NOW orders for Patient #83 did not follow hospital policy for lab turnaround times.

Interview on 12/08/2023 at 1414 with NP #6 revealed her expectation for Patient #83, was for her to have continuous ECG monitoring and vital signs every 2 hours while in the ED. Interview revealed physician orders were not followed for Patient #83.

Interview on12/08/2023 at 1425 with RN #3 who cared for Patient #83 in the Hallway Bed 17 on 11/28/2023 revealed "...I remember her. It was an extremely busy day...she was a hard stick; I used an ultrasound to start her IV. The problem with hallway beds is they have no dedicated monitor. She had a monitor and vital signs ordered. I

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{A1101}	Continued From page 250 strongly advocated for her to get moved into a bed with the CNC (clinical nurse coordinator), and it didn't happen. She didn't think it was a big deal. We don't have the capability to link the patient to a monitor in a hallway bed. She wasn't on a monitor; I spent the afternoon telling the CNC and MD. The doctors don't have any say, it's up to the CNC where patients are roomed. I sat behind her all day, ...I was extremely frustrated..." Interview revealed Patient #83 was not placed on continuous ECG monitoring, nor were vital signs monitored every 2 hours. Interview revealed physician orders were not followed for Patient #83. Interview on 12/08/2023 at 1230 with Nursing Vice President of ED Services, RN #20 revealed she could not explain the lack of telemetry monitoring or vital signs for Patient #83 while in the ED. Interview revealed the ED nurse should elevate to the ED Charge Nurse for the need to continuously monitor a patient in a hallway bed if one was not available. Further interview revealed the ED Provider and ED Nurse were responsible for monitoring lab results via electronic medical record in the ED. Interview revealed hospital policy was not followed for Patient #83. Interview on 12/09/2023 at 1159 with Lab Director #18 revealed "...I do know we had a call out that day. The lactic acid was available for the lab tech to see at 1016 but wasn't called to the floor until 1108. I don't know what the delay was. The expectation was to call as soon as the result was available. The expectation for lab collection and processing was to follow the policy guidelines, and for STAT and NOW results to be completed within an hour..." Interview revealed lab collection and processing did not follow hospital policy for	{A1101}		

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{A1101}	Continued From page 251	{A1101}		

Patient #83.

Patient #83 was presented to the ED with dizziness on 11/28/2023 at 1216. The patient had STAT (immediate) lab work ordered at 1218 with continuous ECG monitoring. Labs were drawn at 1358 (1 hour and 40 minutes after ordered). Labs arrived at the lab at 1412 and resulted at 1532 (3 hours and 14 minutes after ordered). The blood glucose was 1137 (critically high). Insulin IV infusion was ordered at 1626 and initiated at 1709 (1 hour and 13 minutes after ordered and 1 hour and 37 minutes after the glucose resulted). Orders for continuous ECG monitoring placed at 1218, and vital signs every 2 hours were never initiated in the ED. At 2349 an IV infusion of D51/2 KCL was ordered that was not completed until 0157 (2 hours. and 8 minutes after ordered). Lactic acid was ordered NOW at 0127 for nurse collect in the ED. At 0200 a physician wrote there was a delay in labs and fluids so stopped the insulin IV infusion. The lactic acid was not collected in the ED. At 0529 the original lactic acid NOW, order was cancelled and reordered as lab collect NOW on the floor. It was collected at 0844 (3 hours and 15 minutes after ordered at 0529) and resulted at 1108 (9 hours and 41 minutes after originally ordered at 0127) with a result of 7.48 critical high. A second lactic acid was reordered at 1108 and resulted at 1256 (1 hr. and 36 minutes after ordered) with a result of 11.96 critically high. A rapid response was called previously at 1158, the patient was intubated at 1247, and ultimately expired on 11/30/2023.

3. Review of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) /Alcohol Withdrawal Plan, effective date 07/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A1101}	Continued From page 252	{A1101}		

revealed "...Monitoring Phase ...Now ONCE, when plan is initiated with goal CIWA < (less than) 15..." The CIWA/Alcohol Withdrawal Plan Reference Information included 10 questions, questions 1-9 can score between 0 and 7 points each question, question 10, can score 0 to 4 points, depending on severity of symptoms for each question. Score range 0-68. Questions with observations: 1. Nausea/Vomiting? 2. Paroxysmal sweats? 3. Agitation? Headache, fullness in head? 5. Anxiety? 6. Tremor? 7. Visual disturbances? 8. Tactile disturbances? 9. Auditory disturbances? 10.Orientation and clouding of sensorium -Ask what day it is? "...CIWA Management Communication If CIWA > 15 for four consecutive hours, contact provider to initiate Severe Withdrawal Phase and/or to consider transfer to higher level of care..."

Closed medical record review on 11/16/2023 revealed Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of "...chest pain, nausea, clammy, lightheaded, and right-side tingling for several week. Drinks 12 beers a day...." At 1603 triage by Registered Nurse (RN) #21 with vital signs: temperature 98.5, heart rate 97, respirations 18, blood pressure141/89, oxygen saturation of 96 percent on room air, and pain of 4/10 (1 being least pain, and 10 being most pain) and was assigned an emergency severity index [ESI] (level 1 as the most urgent and 5 as the least urgent) of 2. Patient #43 was then moved to the ED waiting room IPA (Internal Processing Area) area and was seen by Nurse Practitioner (NP) #22. At 1650 initial labs, ekg, and chest Xray were completed, and Patient #43 was assigned to ED Medical Doctor (MD) #23. Review of the ER Physician

{A1101} Continued From page 253 {A1101}

Note from 08/14/2023 at 1727 by MD #23 revealed a review of lab, ekg and chest Xray results from 08/14/2023 did not show any critical results. At 1732 MD #23 ordered a GI cocktail (oral combination of medications given for indigestion), Zofran 4mg orally (medication given for nausea and vomiting). An addendum to MD #23's ER Report Note revealed "...On reassessment patient and his mom who is now accompanying him are updated on his results. He is still in the waiting room unfortunately. I have ordered IV (intravenous) fluids, CIWA protocol and 1mg of Ativan (a sedative given for anxiety and seizures) as he is slightly tremulous (shaking) and diaphoretic (sweating) my reassessment [sic]...Hospitalist has been consulted for admission..." At 1841 MD #23 placed orders for IV (intravenous) fluids-NS NOW, thiamine (dietary supplement/nutrient) 100 milligrams (mg) orally STAT (immediately), and CIWA scale/protocol (alcohol withdrawal plan/protocol). At 1851 vital signs were rechecked by IPA ED RN #24 temperature 98.3, heart rate of 103, blood pressure 132/82, and oxygen saturation of 92 percent on room air, the GI Cocktail, and Zofran were administered in the ED waiting room. At 1947 MD #23 ordered Ativan 1mg IV push NOW (urgent). Per the CIWA plan at 2100 a multivitamin orally was ordered and CIWA Scale assessment. The History and Physical was initiated on 08/14/2023 at 2229 by Hospitalist MD #25 while in the ED waiting room, and new orders were placed for aspirin orally NOW, Lopressor (medication given in treatment of alcohol withdrawal) 12.5 mg orally, and again IV access at 2226. At 2305 MD #25 ordered Patient #43 phenobarbital (medication given to prevent seizure) 60 mg orally three times a day STAT and a CIWA Scale reassessment was due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 254 to be completed per protocol. No nursing reassessments, medication administrations, IV access/fluids, or physician orders were completed after 1851 for Patient #43 while in the ED waiting room. On 08/15/2023 at 0057 Patient #43 was moved to the Red Pod (ED area for the most acute patients) room 11. At 0105 MD #25 ordered Patient #43 to have Ativan 4mg IV STAT and was given at 0106 by RN #27. Review of the ER Report Note on 08/15/2023 at 0107 by MD #26 revealed "...I became involved in the patient's care after he apparently left the waiting room where he was awaiting admission and then had a seizure and struck his head on the sidewalk outside of the ER (emergency room) entrance. On my evaluation, the patient seems postictal (the period following a seizure, disorienting symptoms, confusion, and drowsiness), he is not actively seizing. He does have a history of heavy alcohol use, drinks about 12 beers a daily. He has been in the emergency department waiting room for 9 hours and has not received any Ativan or Phenobarbital. I suspect that he seized due to alcohol withdrawal. Will obtain head CT (cat scan) given the patient did strike his head, he also has a small laceration that will require repair. ..." Record review revealed the ED waiting room orders for IV fluids NOW on 08/14/2023 at 1841 to 08/15/2023 at 0106 (5 hrs. and 25 min), Ativan IV NOW ordered on 08/14/2023 at 1947 to administered on 08/15/2023 at 0106 (5 hours 19 min), and Phenobarbital STAT ordered on 08/14/2023 at 2305 to administered on 08/15/2023 at 0150 (2 hours and 45 min) for Patient #43 were delayed and no CIWA score/assessment was completed until 08/15/2023 at 0437 (9 hours and 56 minutes after ordered). No CIWA score/assessment was documented before the patient had a seizure	{A1101}		

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{A1101}	Continued From page 255	{A1101}		

event with sustained head injury. There was no nursing reassessment, or nursing care after 08/14/2023 at 1851 by RN #22 until 08/15/2023 at 0057 (6 hours and 1 minute). Patient #43 was admitted to an inpatient room on 08/15/2023 at 0334 from the ED. Patient #43 was discharged home on 08/17/2023.

Review of the Patient Care Analysis (Incident) report submitted by MD #25 on 08/15/2023 at 0443 revealed the date of event was 08/15/2023 at 0000. Brief description revealed "...patient was in waiting room for 9 hours, did not receive any medications for alcohol withdrawal, then had a seizure and sustained a head injury..." Investigator #28 Notes revealed: We continue to work through ways to provide care to patients in the waiting room during peak times of surge and limited staffing..." Further comments were reviewed by the hospital Pharmacy, dated 11/17/2023 (3 months after the event) that revealed "...Suggest education to send out of CIWA precautions...Nurse could have clarified with provider about the CIWA order and administered medication..." Level of Harm was documented as "Harm-required intervention" and Primary Action to Prevent Recurrence: "Increase in Staffing/Decrease in Workload."

MD #23 declined to be interviewed.

Interview on 11/15/2023 at 1414 with MD #26 revealed "...With the current process it's still difficult to treat patients in the ED waiting room. The goal was for delays in care to not happen, but especially at night it occurs. I have concerns with delays in patient care. The patient was better off in a more clinical area where they can be monitored ..." Interview revealed MD #26 had

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 256 concerns for patient safety in the ED waiting room due to delays in patient monitoring. Interview on 11/15/2023 at 1615 with NP #36 revealed "...it does happen occasionally that orders in the ED waiting room are on hold until the patient can be roomed. I do have concerns about it. The new waiting room flow is not better..." Interview revealed NP #36 had concerns provider orders were not completed timely in the ED waiting room. Interview on 11/16/2023 with ED IPA Day RN #22 revealed she did not remember Patient #43. Interview revealed "...best practice was to go back to see if patients' meds (medication) were helpful. I must have left before I was able to put in a reassessment...I work IPA and the waiting room. There are multiple nurses and nurse techs (technicians) who get vital signs in the lobby and the techs notify us if abnormal. We escalate patient concerns with the charge nurse and the doctors do the same..." Interview revealed RN #22 cared for Patient #43 until 1900 and did not remember doing a reassessment after medication administration. Interview on 11/28/2023 at 1639 with ED IPA Night RN #28 revealed she did not remember Patient #43. Interview revealed "NOW orders in the IPA area go by priority and ESI, we are not always able to do them. The CNC (clinical nurse coordinator) should be informed...If you are the only IPA nurse and the doctor says 'this has to happen now' then it's the next on my list. There was no protocol for who was actually assigned patients in the waiting room. Reassessments for ED patients who are waiting in the lobby would fall under the IPA nurse tasks but they are doing	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 257 other patient's needs and medications as well. There were only two ways to know if additional orders are placed on a patient after IPA, the doctor tells you, or on the tracking board, you might see "repeat troponin", the CNC was supposed to help with that. If I gave controlled medication in the waiting room, I am responsible for the reassessment. If we are caught up it is a part of our duties to reassess..." Interview revealed patients in the ED waiting room are not assigned a nurse for reassessment and monitoring. Interview revealed hospital policy for reassessment in the ED was not followed for Patient #43. Interview on 12/01/2023 at 1130 with ED IPA RN #35 revealed "...The IPA nurse continues to be responsible for patients in the waiting room, after initial orders were completed..." Interview revealed the IPA nurse should continue to reassess patients in the ED waiting room. Interview revealed hospital policy for reassessment was not followed for Patient #43. Interview on 12/08/2023 at 1230 with Nursing VP of ED Services, VPED #20 revealed she could not explain the lack of monitoring or completion of provider orders in the ED waiting room. Interview revealed any new outstanding provider orders for patients in the ED waiting room would be elevated to the CNC. Further there was a WebEx huddle (meeting virtually for many hospital departments to discuss and prioritize patient needs) held every 2 hours and any outstanding provider orders would be delegated to be completed. Interview revealed RN #20 could not explain why Patient #43's reassessments and providers orders had not been completed.	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 258 Patient #43, a 39-year-old who presented to the emergency department (ED) by private vehicle on 08/14/2023 at 1603 with complaints of chest pain, nausea, clammy, lightheaded, right-side tingling for several weeks, with a reported history of drinks 12 beers a day. Review revealed the patient was located in the waiting room area and was observed by a physician to be diaphoretic. The physician ordered intravenous (IV) fluids and CIWA protocol (assessment tool used for alcohol withdrawal) at 1841, and Ativan (medication for anxiety) was ordered at 1947. These orders were not implemented. Multivitamin was ordered at 2100. Another order was placed at 2226 for IV fluids and Lopressor. Aspirin was ordered at 2229. None of these orders were implemented. An order written at 2305 for Phenobarbital administration was not implemented. At 0107, a physician's note referenced the patient had a seizure and fall with a head injury outside the ED waiting room area. Findings revealed the patient had delays with nursing assessments, and failure to implement orders, including medication administration, and following the CIWA protocol. The patient subsequently had a seizure and fall with a resulting head injury. 4. Closed medical record review on 11/14/2023 revealed Patient #28, a 48-year-old male patient who arrived at the emergency department (ED) by emergency medical services (EMS) on 07/05/2022 at 0947 with headache x 2 weeks, altered mental status, fall, and was combative. He was triaged at 0950 by RN #57 with vital signs temperature 97.8, pulse 79, respirations 24, blood pressure 175/86, oxygen saturation of 94 percent on room air, a pain scale of 0 and an emergency severity index (ESI) of 1-Resusicitation. At 0955 Medical Doctor (MD) #59 initiated orders for EKG,	{A1101}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 259 lab work, chest Xray and CT (cat scan) of the head. At 1005 Haldol (given to treat severe behavior) 10 mg Intravenous was ordered by MD #59 and given due to combativeness. Review of the ER Note by MD #59 dated 07/05/2023 at 1002 revealed ".....history unable to be obtained from the patient. he was combative with EMS requiring 5 mg (milligrams) of Versed (given for sedation) given IV. He is only slightly sedated right now,... pulling at lines, not answering questions, and not following commands. " At 1005 the complete blood count resulted with a white blood cell count of critical high- 32.4 (normal high 11). At 1029 Normal Saline 1 liter IV bolus was given and Rocephin (antibiotic) 1 gram IV was administered. At 1045 vital signs were pulse 78, blood pressure 226/107, oxygen saturation 98 percent on room air. At 1050 Patient #28 was intubated (mechanical ventilation) with standard IV sedation protocols. At 1054 vital signs pulse 76, blood pressure 211/91, and ventilated at 98 percent oxygen saturation. At 1236-1311 Patient #28 went into ventricular tachycardia (lethal heart rhythm) and was coded (resuscitated by staff), defibrillated, and had a central line placed. At 1322 a lumbar puncture was completed by MD #59 and a meningitis panel was ordered. At 1322 the cerebrospinal fluid (CSF) white blood count (WBC) resulted high at 94000 (normal high range 5 WBC's per mm3 [million cubic meters]. At 1324 more antibiotics were given IV. Review of the ER Report Reexamination/Reevaluation (not timed) by MD #59 revealed ". the patient ultimately did require intubation for sedation and airway protection, his mental status continued to worsen despite Haldol and Versed.. The Head CT was negative. Once back from CT the patient became profoundly hypotensive and at 1 point	{A1101}		

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{A1101}	Continued From page 260 lost pulses requiring CPR, total time roughly 5 to 10 minutes...We have been running norepinephrine (given to sustain blood pressure) through this...ICU (intensive care unit) has been consulted. Family additionally has been updated..." At 1409 Pulmonologist/ICU MD #60 ordered Levophed (used to treat life-threatening low blood pressure) 4mg/ in 250 milliliters (ml) to titrate to 30 micrograms (mcg)/per minute and was initiated by RN #56 at 1514 (1 hour and 5 minutes after ordered), and at 1655 this drip rate was adjusted to 20mcg/min. At 1740 blood pressure was 137/79, at 1750 blood pressure was 73/42, at 1800 blood pressure was 33/18. Review of the Medication Administration Record revealed at 1801 RN #68 initiated a bag of Levophed at 30 mcg/min for Patient #28. At 1803 a code was initiated, and Patient #28 was in asystole (no heart rhythm). The code ended at 1807 with the return of blood pressure. At 1814 blood pressure was 249/118 with a pulse of 145. At 1816 an addendum to the ER Report by MD #62 revealed "...At 1803 I was called to the patient's room, who had gone asystole. I was notified of the patient's diagnosis of meningitis and hypotension. CPR was in progress on my arrival...I was notified that the patient's Levophed had run dry, and that the patient had been hypotensive (low blood pressure) sometime before coding...Shortly after the epi (epinephrine-used to return pulse) and bicarb (bicarbonate improves outcomes in cardiac arrest), (1807) we had return of pulses. Patient's blood pressure high. ICU attending entered shortly after the code finished." At 1940 Patient #28 was transferred to the medical ICU for admission. Patient #28 continued to decline and showed no signs of improvement. Review of the Discharge Summary date 07/15/2022 at 1525 by	{A1101}		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 261 Doctor of Osteopathic Medicine, DO #63 revealed "...There was no change in neurology exam, and it was explained to the family that there were no signs of meaningful improvement. At this time the family changed its code status to DNR (do not resuscitate) ...at this time the family was amenable...for organ procurement. He was brought to the OR (operating room) this morning where he was extubated (removal of mechanical ventilation), and time of death was 1040. On 07/15/2022 at 0931 Patient #28 had his kidneys harvested and was pronounced dead at 1040. Review on 11/28/2023 of the Patient Safety (Incident) Report for Patient #28 revealed it was reported by: (named RN #57) on 07/05/2022 at 1930. Event #: 6858. Event time was 07/05/2022 at 1803 with brief description "...assigned 5 patients, pt. (patient) coded due to unsafe staffing ratio...additional comments ...NUS (nursing unit supervisor RN #74) and Director (named, RN #75) notified of unsafe assignment at approx. 1730. RN (named RN #56) responded to assigned Trauma Alert which arrived at 1748. Pt. coded at 1803, 1 round of CPR, epi, sodium bicarb, ROSC (return of spontaneous circulation). Pt's levophed emptied due to unsafe staffing assingment [sic]which was reported to NUS and Director prior to event..." Review on 07/06/2022 by Investigator and Director of ED Services (named RN #76) revealed one of the ED managers had spoken to Patient #28's family member. The family was upset because they had "...asked for help at the doorway of the patient's room when she noted alarms going off in the room. A PA (PA#77) was at the nurse's station from a different service line that reportedly did not respond to her request..." Further the CNC, RN #74 reported she was only notified RN #56	{A1101}		

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{A1101}	Continued From page 262 needed assistance when the patient was coding. Patient #28 did code 2 times during his ER stay and had a length of stay of 9:52 (9 hours and 52 minutes) in the ER. RN #56's patient assignment was broken down by RN #76 in the report as two stable patients awaiting admission to step down units (2), one patient who had been moved to the hallway (1), a new Trauma Alert patient (1), and Patient #28, an ICU patient (1). (RN #56 was assigned and responsible for 5 patients during Patient #28's code/event). RN #76 discussed collateral staff available in the ED to support RN #56. "...Background information: The House was unable to provide staffing support for the admit holds in the ER on this date. There was an ER census of 295 on this date..." On 07/07/2022, Vice President (VP) of ED Services, VPED #48 reviewed this Patient Safety Report. Her investigation revealed there was an additional Patient Safety Report for this same event "...Indicating that the ER Director was informed of an alleged unsafe patient assignment. This notification to the Director was not substantiated..." Additionally, VPED #48 agreed RN #56's assignment was safe due to collateral staffing in the ED. And did mention Patient #28's family had voiced concerns who did not respond to their request for help for alarms in the room with (named, PA #77). The Primary Contributing Factor was "Human Factors/Staff Factors...Competing priorities...Level of Harm Harm-intervention to sustain life..." In summary, Patient #28's levophed IV infusion sustaining his blood pressure was allowed to run dry, his blood pressure dropped, he was coded for 7 minutes until the infusion was reinstated. RN #56 had a patient assignment of 5 patients. Review on 11/28/2023 of the Patient Safety	{A1101}		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 263 Analysis report, Event #6856, referencing Patient #28 dated 07/05/2022 at 1843 by ED Clinical Pharmacist, ED RPH #78 revealed the event date was 07/05/2022 at 1800 with a brief description of "...Patient required CPR (cardio-pulmonary resuscitation) due to levophed running dry while RN was attending to other patients (RN had 5 pts), including two traumas and this ICU patient...additional comments...making this report on behalf of (named RN #56) as he does not have time to make report. (Named) had 5 patients: the patient from this report (named) intubated, ICU), a trauma alert, a trauma transfer-a comfort care patient in the hall, and two other admitted patients. While he was in one of the traumas, this patient's norepinephrine infusion ran dry-the patient became hypotensive. The family of the patient was monitoring the BP (blood pressure) and tried to get help from a non-ER provider who was sitting at a computer outside the room and this provider told the family that he could not help them because it was not his patient. Family is irate about this. A few minutes later, another RN came into the room and was able to switch out the levophed, but by this point the pt's SBP (systolic blood pressure) was in the 30's. He then became aystolic and required a round of CPR. (Named RN #56) alerted the ER NUS throughout the day that his assignment was unsafe. This patient coding was a direct result of an unsafe and unreasonable assignment..." This Report was investigated by ED Director, RN #76 on 07/06/2022 without any new findings from previous Event #6858. Additionally, on 07/21/2022 Doctor of Pharmacy, PharmD #79 added investigator notes to this report. The leading description of harm cited by PharmD #79 was "Human Factors/Staff Factors...Level of Harm...Harm-intervention to sustain life..." A	{A1101}		

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{A1101}	Continued From page 264 summary of her report revealed that a bag of levophed was pulled for Patient #28 on 07/05/2022 at 1511 by RN #56 and was documented on the Medication Administration Record as given on 07/05/2022 at 1514, and per her estimation of the rates of infusion, the bag of levophed "...would have likely run out 1745..." The next bag of levophed was pulled on 07/05/2022 at 1757 by ED RN #68 and was started at 1801 for Patient #28. Review revealed Patient #28's levophed IV infusion was interrupted for 16 minutes; he was coded from 1803 to 1810 before returning to spontaneous circulation. Request to interview ED RN #68 revealed she was not available for interview. Request to interview ED RPH #78 revealed she was unavailable for interview. Request to interview ED Manager RN #75 revealed he was unavailable for interview. Request to interview ED Director, RN #76 revealed she was unavailable for interview. Interview on 11/15/2023 at 1014 with RN #56 revealed he remembered Patient #28 and had worked in the ED for 5 years. Interview revealed "...I had trauma bay 11, and rooms 10, 9, 8 initially. The patient in room 10 was combative, intubated and a danger to himself and was receiving the maximum dose of levophed to keep his blood pressure elevated. I had him around 10 hours of my day. I got a trauma patient, and they were going to assign me another new trauma patient. Around 1730 I went to CNC (named RN #74) to discuss my assignment and the acuity of my already 4 patients, she put my dying trauma	{A1101}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
{A1101}	Continued From page 265 patient in the hallway, to make room for the new trauma patient even when I explained I felt my assignment was unsafe. I had already approached her that morning after 0800 to explain the acuity of my patients. So, then I went to my Nurse Manager (named, RN #75) to discuss my assignment and was assigned the new trauma anyway. My new trauma patient had just arrived after 1730, I was working with them and didn't realize a code had been called for my intubated patient. When I arrived in the room (named RN #68), the person who was assisting me while I was caring for the new trauma patient, had already hung a new bag of levophed, and the code was in progress. I was very upset. I voiced my concerns, I talked to the administration, to the ethics and compliance committee and filed a complaint with HR (human resources). I tried to document this the best I could..." Interview revealed RN #56 had gone to the CNC, RN #74 at 0800 and again before new assigned trauma patient to voice his concerns with his high patient acuity assignment. Interview revealed RN #56 was caring for another patient, when the levophed IV infusion ran out, causing Patient #28's blood pressure to drop, and a code was initiated. The interview revealed reassessment and monitoring of Patient #28 did not follow hospital policy. (request for all documents filed by RN #56 administration, ethics committee and HR were not made available during the survey). Interview on 11/16/2023 at 1128 with CNC, RN #74 revealed RN #56 approached her one time, and said, 'I need help'. CNC RN #74 stated she got RN #56 help by calling on the trauma team nurses who support trauma patients in the ED, but were not assigned patients in the ED. Interview revealed "...If we need help, we pull	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 266	{A1101}		

resources..." Further interview with CNC RN #74 revealed "...she had no concerns with nursing reassessments in the ED... that nursing assignments in the Red Pod (where the most acute patients are assigned) were 1 RN to 4 patients..." The interview revealed CNC #74 added trauma team nurses to assist RN #56 and stated she and the CNC's filled in themselves when needed to support patient care.

Interview on 11/15/2023 at 1637 VPED #20 during tour of the ED revealed the Red Pod in the ED was assigned the most acute ED patients. The interview revealed nursing assignments were 1 nurse to 4 patients, and RNs are expected to communicate with the CNC's any concerns or delays with patient care. "...starting in 2023 we have Webex huddles with nursing, providers, and other hospital departments every 2 hours to discuss delays in care and appoint resources where they are needed..." Interview revealed the expectation for reassessment and monitoring patients were for all staff to follow hospital policy. Interview revealed hospital policy for Patient #28 was not followed.

Telephone interview on 12/01/2023 at 1209 with Director of the Trauma Team, MD #80 revealed he was aware of the case with Patient #28 and was the Medical Supervisor for PA #77 in 2022 and currently. Interview revealed "...when a Trauma Team member was in the ED it was to care for a specific consulted trauma patient, however a Trauma Team member if clearly evident could assist any patient in a life sustaining emergency..." The interview revealed PA #77 would not be allowed to touch an IV drip or alarming IV pump of a patient they were not consulted on. Interview revealed PA #77 notified a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 267	{A1101}		

person who could adjust the drip for Patient #28. Further interview revealed he had no concerns with PA #77's patient care, and the Trauma Team Supervisor, RN #81 had communicated with PA #77 "...we should always respond with compassion to family..." regarding this event. Interview revealed MD #80 had not followed up with PA #77, the Trauma Team Director had talked with PA #77. Interview revealed PA #77 did not know Patient #28's blood pressure was low or the levophed had run out but had communicated to ED nursing staff who could attend the alarms when family asked him.

Telephone interview on 12/01/2023 at 1241 with Trauma Team PA #77 revealed he had been employed for 8 years. Interview revealed "...I am only in the ED when called/consulted for a specific trauma patient. The family came to the desk, I told them I can get your nurse, and I did. The family was asking about an IV beeping. If I thought he was coding, I would have made sure he was OK. I did not have that information. I only learned about the IV levophed today. Of course, I would respond to help a patient coding. I would not 'shirk' a patient needing help..." Interview revealed PA #77 recalled the family asking for help with an IV alarm. He told the family he would find the nurse, and he did.

Patient #28 presented to the ED on 07/05/2022, was critically ill, intubated and diagnosed with bacterial meningitis. The patient developed a low blood pressure and a Levophed IV drip was started. Findings revealed the Levophed IV drip was allowed to run dry and the patient's blood pressure dropped to 33/18. A trauma PA was requested by the family for help related to alarms and the patient's condition and the PA indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 268 the patient was not the PAs assigned patient. The patient arrested. A new Levophed bag was hung. The patient and IV were not monitored and the bag ran dry with subsequent cardiac arrest. 5. Closed medical record review on 11/14/2023 revealed Patient #27, a 66-year-old female who arrived at the emergency department (ED) on 07/04/2022 at 0025 by private vehicle with abdominal pain, nausea, and vomiting. Patient #27 was triaged at 0025 by RN #38 vital signs: temperature 97.2, respirations 20, heart rate 107, blood pressure 169/93, and oxygen saturation of 94 percent on room air, a pain score of 10 (1 least pain and 10 being the most pain) and was assigned an emergency severity index (ESI) of 3 (urgent). At 0028 Nurse Practitioner (NP) #39 wrote orders for Lipase (a digestive enzyme) STAT, CMP (comprehensive metabolic panel) STAT, Lactic Acid (carries oxygen from your blood to other parts of your body) STAT, CBC (complete blood count) STAT, Urinalysis (Urine test) STAT, and CT (cat scan) of the Abdomen/Pelvis STAT, an IV (intravenous) of Normal Saline to be started and Ondansetron (medication for nausea) 4 milligrams (mg) IV to be given. Record review did not reveal lab work, nursing reassessment, or physician orders for IV and medications were implemented for Patient #27 while in the ED waiting room (6 hours and 3 min). At 0631 Patient #27 was moved to Red Pod (for highest acuity patients) room 20. Patient #27 was seen by MD #26 at 0656 and orders were placed for ondansetron 4 mg, and Dilaudid (narcotic pain medication) 0.5 mg for pain. At 0734 lab work resulted (7 hours and 6 minutes after ordered). At 0739 Patient #27 had an IV started of NS (7 hours and 11 minutes after ordered), and medications for pain (7 hours and	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101}	Continued From page 269 14 minutes after identified pain level of 10, and 43 minutes after pain medication ordered) and nausea (7 hours and 11 minutes after original order) were administered by RN #40. At 0742 vital signs were documented as heart rate 85, respirations 16, blood pressure 174/89, oxygen saturation of 93 percent on room air (no temperature), with a pain score of 10/10 by RN #40. At 0755 the CT of Abdomen and Pelvis (6 hours) resulted (7 hours and 27 minutes after ordered) positive for a small bowel obstruction. Review of the ER Note Reevaluation (not timed) by MD #26 revealed Labs were reviewed without critical results, and the CT scan was consistent with a small bowel obstruction. Surgery was consulted for further evaluation and management by MD #26. At 0839 repeat pain assessment was 1/10 by RN 40. On 07/04/2022 at 1316 Hospitalist #41 saw the patient, set for admission. At 1319 Patient #27 had a pain score of 10/10, vital signs heart rate 83, respirations 17, blood pressure 147/96, oxygen saturation of 93 percent on room air, and was given Dilaudid 0.5mg IV for pain relief by RN #40. Review of the Surgical Consult Physician Note by MD #42 dated 07/04/2022 at 1543, Patient #27 was scheduled for a Laparoscopy, Possible Exploratory Laparotomy with Possible Bowel Resection. At 1620 a repeat pain assessment was completed for a pain score of 3/10. At 1600 Patient #27 left the ED for the operating room for surgery. Patient #27 completed surgery without complications and was discharged home on 07/06/2022 at 1136. Request for a Patient Safety Report (Incident Report) revealed there was not one available. Interview on 11/15/2023 at 1350 with ED RN #38 who triaged Patient #27 revealed "...in 2022 no	{A1101}		

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{A1101}	Continued From page 270	{A1101}		

patients were checked on in the ED waiting room, some changes were made, and there are some improvements. It's very possible that this patient waited without any labs or orders completed. At that time there was one nurse in the waiting room to triage patients. There was no way to complete orders..." Interview revealed nursing reassessments and physician orders were not completed in the ED waiting room in 2022.

Interview on 11/17/2023 at 1102 with NP #39 revealed "...the IPA (Internal Processing Area area in the ED waiting room) did not exist then. Now if patients need to move to the back, I tell the CNC (clinical nurse coordinator), we call and we call. I personally have been pulled to do patient reassessments when there was a change in condition. One hundred percent, patients are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff..." Interview revealed NP #39 had current concerns with waiting room patients not getting orders completed in the ED waiting room.

Interview on 11/15/2023 at 1414 with ED MD #26 revealed "...I saw the patient after she was roomed.....There is not always a person to get labs and orders done. No staff to do orders. With the new process the goal is for that not to happen, but at night I suspect it does. As far as care in the waiting room, this patient didn't get vital signs, or overall assessments and no meds. things are not happening on a timely basis. " Interview revealed Patient #27 did not get vital signs, assessments, or medications as prescribed. Interview revealed hospital policy was not followed for Patient #27.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101}	Continued From page 271	{A1101}		

Patient #27 arrived in the ED on 07/04/2022 at 0025 with a reported pain level of 10 of 10. The patient had a STAT CT of the abdomen and pelvis ordered at 0027 that was not completed until 0755 (7 hours, 27 minutes later) resulted and signed at 0825. The patient had pain reported as 10 of 10, with nausea and vomiting with vital signs at arrival at 0025 and was medicated with Dilaudid (narcotic pain medication) at 0739 (7 hours and 14 minutes after arrival). The patient was diagnosed with a small bowel obstruction and had surgery that day. The patient had a delay with STAT lab work, STAT CT, nursing reassessment and pain management.

6. Closed medical record review on 11/14/2023 revealed Patient #29, a 78-year-old female who presented to the emergency department (ED) via emergency medical services (EMS) on 04/05/2022 at 1451 with complaint of falling at home with a laceration to the right lower extremity. The EMS report dated 04/05/2022 at 1342 revealed the patient had fallen from the toilet at home, was on oxygen 3 liters by nasal cannula "comments: baseline for patient", had an Intravenous (IV) line in her left forearm #20 gauge and had received Normal Saline 700 milliliters. Review of an EMS narrative note revealed "she does have significant bleeding from her right lower leg...bleeding is controlled...the leg is splinted...", was on a ECG (heart monitor) showing a heart rhythm of atrial fibrillation (irregular heart beat) with a pulse of 88. At 1503 a Physician's Assistant (PA) #45 was assigned and a review of his ER Report Note at 1510 revealed "...High suspicion for open fracture to right anterior shin...", with plans to order CT (cat scan) of the head and neck, pain medication,

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 272 antibiotics, and lab work." PA #45 ordered X-rays/CT at 1508. At 1514 Patient #29 was moved to Red Pod (for most acute patients) Hallway Bed 7. At 1517 Patient #29 was triaged by RN #43 "...subjective rapid assessment: fell in the bathroom at home. On Eliquis (blood thinning medication) and a pain score of 0. Open Tib Fib started earlier unseen...Pre-hospital treatments: oxygen, other: 3-liter O2. 20g Left arm...Acuity 5-non-urgent...", an emergency severity index (ESI) was assigned of 5 (Non-Urgent). At 1536 lab work was ordered. At 1537 the CNC (clinical nurse coordinator), RN #44 documented a change in patient ESI to 3-urgent. 1559 lab work had resulted. At 1618 PA #45 ordered Hydromorphone (narcotic pain medication for severe pain) 0.5 mg IV push every 15 minutes duration 3 doses for pain for Patient #29 and Zofran 4mg IV for nausea. At 1630 (one hour and 39 minutes after arrival) vital signs were documented as pulse 88, blood pressure 161/79, oxygen saturation of 90 percent (no oxygen was documented), 1639 respirations of 22, and temperature of 98.4. By 1627 all radiology had resulted, and a review of the ER Report Reexamination/Reevaluation (not timed) by PA #45 revealed "...On my read it appears the patient has a rather significant tib-fib (tibia/fibula) fracture. I do believe this is an open fracture. She has already received Ancef (antibiotic), and I have already spoken to orthopedic surgery. They will come and speak with the patient..." At 1636 Ancef 1 gram IV, a Tetanus (infectious disease that can occur from an unclean wound) booster intramuscular, Hydromorphone 0.5mg IV for a pain score of 10/10 and Zofran 4mg IV were administered by RN #43(no evidence of an oxygen assessment). At 1736 a pain reassessment was charted as 9/10 (no evidence	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 273 of an oxygen reassessment). At 1748 the Orthopedic Consult and History and Physical was completed by MD #52 with diagnosis of "Open tibial shaft fracture..." with plan for surgery to repair fracture. Review of the ER Report addendum by PA #45 (not timed) revealed "...Orthopedic surgery agrees this appears to be open fracture and recommends a room for splinting and simple reduction before surgery tomorrow am..." At 1816 Patient #29 was given Dilaudid 0.5mg IV for a pain score of 9/10 by RN #43 (no evidence of oxygen assessment). Review of the Patient Summary Report revealed Patient #29 was moved to room 11 at 1915. Review of an addendum to the ER Report by PA #45 (not timed) revealed "...As I was handing off the patient to ... I was told by nursing staff that the patient was unresponsive. Upon arrival at the bedside, the patient is unresponsive. She does have DNR (no evidence of this in the record). She is moved into room 11 where Dr. (MD #46), my attending physician was kind enough to evaluate the patient and call time of death..." Review of the ER Report 04/05/2022 at 1947 by MD #46 revealed "...78-year-old female past medical history of atrial fibrillation currently anticoagulated on Eliquis. She fell and had an open fracture of the tibia/fibula. Patient has been admitted to the orthopedic service. I was called to the patient's bedside at 7 PM as nursing found her pulseless and apneic (no respiration). After 60 seconds, the patient has no cardiac activity, she is in asystole (no heart rhythm) on the monitor. Her pupils are fixed and dilated. No spontaneous respirations, no cardiac sounds and she is pulseless. Official time of death was called at 709 PM ..." Patient #29 was pronounced dead in the ED on 04/05/2022 at 1909.	{A1101}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 274 Review of the Patient Event Record dated 04/06/2022 at 0341 by Nursing/Surgical Services #54 revealed the event was "unexpected death" date of event "04/05/2022 at 1903" with narrative "...pt came to ER (emergency room) c/o (complaint) fall with fracture. pt placed in the hall bed. pt found unresponsive in hall...House Supervisor (RN #55) notified at 1905...", the description of harm and action to prevent reoccurrence was documented as "monitor trends and patterns". There was no witness to the event per the report. Trauma Nurse, RN #56 as unavailable for interview. Interview on 11/16/2023 at 1204 with ED RN #43 who cared for Patient #29 revealed "...I was checking on the patient, she was responding, her daughter was there. I was charting and could see her. She was full code, her daughter ran over to me and asked me what I was doing, as I was pulling the stretcher away from the wall and replied 'CPR' and the daughter said, 'please don't do that'. The trauma nurse that day, (named RN #56) took the patient to room 11. I reported it to my charge nurse (named RN #57), and I went to report off on my other patients because it was the end of the shift. I didn't see her again...you'll have to go by my charting, I don't remember if she was on oxygen..." A further interview revealed "...I should have charted she expired, that was an error..." The interview revealed RN #43 did not recall if Patient #29 received oxygen in the ED, did not recall if an oxygen reassessment was completed and did not get vital signs or reassess a change in condition. Interview revealed hospital policy for reassessment was not followed for Patient #29.	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 275 Telephone interview on 11/16/2023 at 1324 with MD #46 revealed she did not recall Patient #29. Interview revealed "...monitoring of patients in hallway beds are a concern. Ideally every patient in the Red Pod should be on some sort of a monitor with a pulse oximeter. More monitoring is always better..." Interview revealed when MD #46 arrived at the patient's bedside she was in asystole, and she pronounced the patient with daughter at the bedside. Interview on 11/16/2023 at 1747 with CNC, RN #44 revealed "...I do remember she was in a hallway bed, and (named RN #43) said she had passed. I had checked on her. (Named RN #43) told me the daughter came to her and said, 'somethings wrong with my mom'. I don't remember if she had oxygen or was being monitored. I would expect the ED nurse to complete assessments and document them in the chart...Staffing was 4:1 in the Red Pod, If a nurse tells me I'm overwhelmed, I will ask another nurse to assist with patient care..." Interview revealed RN #44 did not know why oxygen reassessments or changes in conditions were not completed for Patient #29. Interview revealed hospital policy for reassessment for a change of condition was not followed for Patient #29. Interview on 11/28/2023 at 1433 with Assistant Director of Nursing, RN #15 to review the internal investigation following Patient #29's death in the ED "...Per the ED Manager (not identified) the patient's family called staff over to the patient because 'she didn't look good'. She was unresponsive and was taken to room 11 to be placed on a cardiac monitor which showed asystole. At 1909 was the time of death	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A1101}	Continued From page 276 pronounced with her daughter at the bedside. Interview revealed this event was reviewed by the Mortality and Morbidity which was comprised of multiple providers and the MD who had completed the report dated 07/11/2022 the internal investigation of Patient #29's death revealed the patient was under triaged, the door to antibiotics was greater than 1 hour, and needed closer monitoring. (note: this surveyor was not allowed to hold or view documents during this interview.) Patient #29 arrived on 04/05/2022 at 1451 via EMS and had atrial fibrillation (abnormal heart rhythm) on arrival. The patient had a recent fall with fracture prior to arrival. Pulse Oximetry was 94% prior to arrival. 1630 pulse oximetry was 90% (1 hour and 39 minutes after arrival) with no evidence of oxygen administration at hospital. Dilaudid 0.5 milligrams (mg) IV was administered at 1630 and at 1816. No vital sign or oxygen assessment on an elderly patient was assessed on the patient with a prior pulse oxygen of 90% after the administration of Dilaudid. The patient was subsequently asystole at 1909 and expired. Patient #29 had one set of vital signs from 1451 until time of death at 1909 (5 hours and 18 minutes). Nursing staff failed to reassess the patient after narcotic administration. Nursing staff failed to reassess the patient for a change in condition (not breathing). 7. Medical Record review, on 12/14/2023, revealed Patient #6 arrived to Hospital B via EMS on 10/03/2023. Review of the Triage Note at 1723 revealed " ...Reason for Visit: Pt (patient) at 2 started having left sided arm and leg muscle weakness and left sided diminished sensation on leg. Facial drooping noted in lower face. No blood	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 277 thinners and 10 days post partum. What aspect of reason for visit is concerning to patient? : Stroke symptoms. ..... " Review of a MD "ER Report", service date/time 10/03/2023 at 1714, revealed " .... History of Present Illness 22-year-old female with a past medical history of vaginal delivery 10 days prior..... who presents to the emergency department with left-sided weakness. Patient states that she felt normal when she went to take a nap at approximately 2 (2:00), when she woke up at 330 (3:30) she noticed that she had weakness on the left side of her face and is developing weakness in the left side of her body. She notes that she was unable to smile fully. States that she has never had any symptoms like this in the past. She notes that last night she had an episode of epigastric pain, but that has gone away since fully. States that the developing left-sided weakness has been ongoing since that time and called EMS for evaluation. Pregnancy was uncomplicated ....Initial Vitals T: 98.9 F Oral HR: 65 RR: 20 BP: 170/97 SpO2: 87%.....Medical Decision Making ....22-year-old female presenting to the emergency department secondary to onset of neurologic deficit with last known normal of approximately 2:00 PM. On exam, I initially had concern for Bell's palsy given her age and demographic info, but on my physical examination I noted appreciable weakness on the left side of the body with regards to motor function. I would not expect Bell's palsy to cause the symptoms, in addition to this she was able to raise both eyebrows equally. Although there can be varying degrees of eyebrow raise or inability to thereof with Bell's palsy, I would not expect the left-sided sensory subjective deficit and motor deficit as noted. Therefore I did initiate a code stroke procedure. This is also complicated by the	{A1101}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 278 fact the patient is 10 days postpartum which does place her at an elevated risk for ischemic CVA (stroke). Differential at this point would also include complex migraine, preeclampsia/eclampsia (serious pregnancy complication characterized by high blood pressure), or complex partial seizure, though she did not report any seizure-like activity .... Ultimately, the decision was made in concert with the stroke neurologist at (Hospital A) not to provide thrombolytics at this point in time .... However, patient will require transport to (Hospital A) for further close work-up and likely MRI (Magnetic Resonance Imaging- type of diagnostic testing). Ultimately my concern for eclampsia (serious pregnancy complication) is certainly present given her elevated blood pressure and abnormal neurologic exam. I did order 20 mg of IV labetalol (to treat BP) to be given as a stat dose in addition to 4 mg of magnesium as a bolus with a 2g/h (grams per hour) infusion thereafter. I did reach out to and speak with the OB/GYN on-call..... who agreed with this management plan and possible diagnosis of eclampsia given her blood pressure and symptoms. Patient was transferred to (Hospital A) emergently for further care. .... Diagnosis/ Disposition Postpartum eclampsia/stroke. ..... " Review of the EMS (Emergency Medical Services) Patient Care Record, dated 10/03/2023, revealed EMS transported Patient #6 from Hospital B to Hospital A. The EMS record indicated they arrived to Hospital A at 1938. Review of the EMS Narrative note revealed "(EMS) on scene at (Hospital B) and was informed of a Red Transport (red is the most urgent transport)......Arrived to find the pt (patient) in room 3, alert to EMS presence and in no	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 279 obvious distress....report is as follows: .....Dx (Diagnosis): HTN (hypertension) crisis, Preeclampsia Stroke HPI (History/Physical): Came in with EMS for L (left) sided drooping and weakness and tingling onset....10 days postpartum.... CT Head clear for bleed and clots 'Preeclampsia Stroke' Meds: Mag (Magnesium) 4 g (gram) Bolus with 2 gm/hr infusion, Labetalol 10 mg (milligrams) ....Vitals: 172/98 Pt states that she feels fine just feels super weak but denies any pain or N/V (Nausea/Vomiting). Due to the importance of medication, (EMS) waited for nurses to retrieve and start a magnesium (Mag) drip before departing. In the meantime, secondary IV access obtained by Paramedic (name) and pt is moved over to the stretcher, placed on all monitoring...... Pt was placed on capnography (carbon dioxide monitoring) noting elevated rate and borderline hypocapnia (decrease in carbon dioxide levels below normal) with normal appearing waveform .... Once all paperwork is obtained and Mag is started pt is moved out to the truck and transport is initiated to (Hospital A) Emergency. Enroute pt is monitored with no new complaints. .. While waiting on a bed at (Hospital A) pt was monitored with minimal changes to her BP. Repeat neuro checks were completed periodically... Pt began to complain of a mild headache and posterior neck pain similar to how she felt before she delivered. Pt report and care given to RN (Name) bedside .... Arrived: 19:40 ......Transferred Care 22:24 (2 hours 44 minutes after EMS arrived to the hospital). Review of the EMS Record revealed EMS staff continued to monitor the patient, including ongoing vital signs. An EKG was performed at 2016. An EMS assessment was completed at 2121 which indicated slight yellowing of the skin, right upper quadrant tenderness and left arm and	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101} Continued From page 280 {A1101}

leg weakness along with a facial droop and neck pain. Vital signs continued approximately every 5 minutes, with the last recorded blood pressure 147/90 at 2215.

Emergency Department record review revealed Patient #6 arrived to Hospital A on 10/03/2023 at 1942. An "ED Triage" performed on 10/03/2023 at 2227 (2 hours 45 minutes after arrival) revealed "...Subjective Rapid Assessment Stated Reason for Visit : Brought by EMs (sic) team from (Hospital B) due to stroke like symptoms, left facial droop and left sided weakness, last known normal was 1400H (hours) and onset of symptoms at 1530H .....ED Full Triage Arrival Mode - ED (Emergent) : EMS .....Pre-Hospital Treatments : IV Access, Other: Magnesium sulfate at 2g/hr ....Arrived From: Hospital..... " Review of vital signs revealed a heart rate of 82, respiratory rate of 18, BP of 168/96, oxygen saturation of 93% on room air and a pain score of 4. Record review revealed an "ED Medical Screen Exam Form. ... Entered on 10/03/23 22:23 EDT" which noted ". MSE Comments : tx (Transfer) from (Hospital B) for MRI brain, concern for ecclampsia. Appears admit bed is already ordered." Review of the "ER Report", service date/time, 10/03/2023 at 2310, revealed "...Patient presents as a transfer from outside hospital for concern of strokelike symptoms. She presented to (Hospital B) today with left facial droop that she noticed when she woke up from her nap around 3:30 PM. Her last known well was around 2 PM. At (Hospital B), she was noted to have left facial droop as well as some left arm and leg weakness. Stroke consult was called and the patient was seen in concert with telemetry neurologist decision was made against using tPA (breaks down blood clots). She was transferred

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 281 here for further stroke eval and MRI (magnetic resonance imaging). She was also notably hypertensive at outside hospital with blood pressure 160s systolic. She has also had some headaches recently, did have a headache at the time of her delivery. She denies any chest pain or shortness of breath currently. ... Physical Exam ....Initial Vitals HR: 82 RR: 19 BP: 168/96 SpO2: 93% .... Neurological: Alert and oriented to person, place, time. Patient does have left facial droop with left eyebrow droop as well. Has very mild drift on the left as compared to right. Has difficulty lifting left leg up against gravity .... Medical Decision Making ...... Differential Diagnosis.....Stroke, eclampsia less likely given no seizures, preeclampsia, Bell's palsy although this is less likely given her symptoms in the left arm and leg ....Treatment and Disposition .... Patient presents the emergency department with left sided weakness and left facial droop. Chart reviewed from outside hospital as she is a transfer from (Hospital B). Discussed with neurologist who will admit to their service. MRI and MRV (magnetic resonance venography-imaging that focuses on the veins) have been ordered. Patient continues to have left facial droop on exam, does seem to have eyebrow sparing as she is able to lift her left eyebrow. She also does have some very mild pronator drift on the left side as compared to the right as well as difficulty lifting up her left leg .... Concern remains for stroke. MRI has been ordered and MRV as well as ordered by neurology. I did discuss the case with OB given her hypertension here. I have ordered the magnesium infusion at 2 g/h as well as a 10 mg dose of IV labetalol given her systolic of 168 here. Patient admitted to neurology .... Diagnosis/Disposition Left-sided facial droop	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 282 Preeclampsia...... " Record review failed to reveal acceptance and monitoring of Patient #6 by nursing until triage at 2227 (~2 hours 45 minutes after arrival). Record review did not reveal documentation of a physician evaluation until 2310. Record review revealed the only documented evaluation and monitoring of Patient #6 during the time period from arrival to triage was from EMS staff. Patient #6 was moved from the initial ED room to a holding unit and later to a maternal fetal medicine unit. The patient was discharged home on 10/06/2023. Telephone interview with EMS #63, on 11/14/2023 at 1430, revealed the EMS team was at Hospital B dropping off another patient and were notified of a "red" transfer of a patient who was 10 days postpartum with a hypertensive crisis and preeclampsia or stroke. Interview revealed they were notified that Neurology wanted the patient transferred emergently. Medications were started and the patient immediately transferred. Patient #6, per interview, was still having symptoms and waited at Hospital A for a "2 hour 46 minute wait time on the wall" (location where EMS waits in the ED with patients who are awaiting an available bed). Interview revealed EMS continued to monitor the patient closely as Patient #6 had right upper quadrant pain and was on a Mag Drip. Interview revealed that EMS waiting and patients holding for a bed had been an ongoing issue for 3 ½ years and seemed to be getting worse. Interview revealed the EMS staff member did not feel the patient's care was met in the ED as Patient #6 required neuro checks, vital signs and close monitoring. Interview with RN #64 during observation on 11/13/2023 around 1030 revealed that when EMS	{A1101}		

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{A1101}	Continued From page 283	{A1101}		

arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible."

Telephone interview on 11/15/2023 at 1410 with DO #65 revealed the DO went to assess Patient #6 when she was in a bed in the ED. Interview revealed the DO signed up for Patient #6 as soon as her name popped up on the ED tracking board. Before that time, the DO was not aware the patient was in the department. Interview revealed that technically the patient was already admitted, having been accepted by neurology, but was an ED to ED transfer. ED physicians still did a full medical screening on transferred patients, the DO stated. Interview revealed Patient #6 was on a Mag infusion and was hypertensive. Interview revealed DO #65 called the accepting Neurologist and also called an Obstetric Resident since the patient was postpartum and hypertensive and there were concerns for preeclampsia.

Telephone interview with Patient #6's Triage Nurse, RN #66, on 11/17/2023 at 0932, revealed the nurse did not recall Patient #6 or the situation.

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{A1101}	Continued From page 284 Interview revealed the EMS team was responsible for any patient they brought in until the patient got a room assignment and was moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Telephone interview on 11/17/2023 at 1205 with Medical Doctor (MD) #67, the accepting neurologist for Patient #6, revealed they were concerned enough to transfer the patient to Hospital A even though they decided not give thrombolytics. Interview revealed obstetrics was called since the patient recently delivered and Mag was given more often by obstetrics. Interview revealed the time until the patient was triaged was "a long time." Interview revealed the patient should have received frequent vital signs by staff. The MD stated they often do ED to ED transfers. Interview revealed MD #67 thought he saw the patient when she was in an ED room and that the accepting physicians would not know a patient had arrived to the ED until a call was received from the ED that the patient was there. Interview revealed if they had a room the patient would have gone to Neuro. Ultimately, the MD stated, it was determined Patient #6 was hypertensive related to pregnancy and it was better for her to be admitted to obstetrics. Patient #6 arrived to Hospital B with strokelike symptoms at 10 days postpartum. She was accepted for transfer to Hospital A as an ED to ED transfer. Patient #6 arrived to the hospital via EMS on 10/03/2023 at 1942. The patient waited in the ED for a bed and continued to be managed by EMS. No documentation was noted by a medical provider until 2223 and Patient #6 was	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C **02/23/2024**

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{A1101}	Continued From page 285 not triaged or assessed by hospital nursing staff until 2227 (approximately 2 hours 45 minutes after arrival by EMS). There was a delay in accepting the patient and a delay in triage, assessment and monitoring by nursing staff. 8. Hospital B Medical Record review on 12/16/2023 revealed Patient #1, a 64-year-old, arrived to Hospital B on 10/31/2023 at 2203. Review of the ED Triage, at 2203, revealed " ...Subjective Rapid Assessment Stated Reason for Visit : 2130 onset slurred and right sided weakness with facial droop; no thinners (blood thinning medications) .....CODE STROKE. ED Full Triage ....Acuity : 1 (highest acuity). ....." Review of the "ER Report" by a physician, at 2212, revealed ".... History of Present Illness This patient is a 64-year-old woman.... here with neurologic symptoms. Independent history is obtained from the patient's husband, who is here with her. He said that at approximately 9:30 PM, she called out to him that something was wrong. He looked over and saw that she was having difficulty walking and seemed to be slumping to the side. Her speech was noted to be slurred..... She is weak on the right side. Physical Exam ....Initial Vitals .... BP: 204/100. .. VITAL SIGNS: Triage vital signs are reviewed and show elevated blood pressure approximately 204/100, otherwise normal. GENERAL: Patient is well-developed, well-nourished, and clearly with facial asymmetry and slurred speech...... NEURO: The patient has paralysis of the right lower face. ....She has moderate dysarthria (slurred speech)...... Level of consciousness seems normal. She does have drift of the right arm without hitting bed..... Medical Decision Making This patient presents with neurologic symptoms concerning for acute ischemic stroke I think she will likely be a	{A1101}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 286 candidate for thrombolytics assuming that we can get her blood pressure down. She is going to CAT (computerized axial tomography - type of diagnostic imaging) scan right now. We are giving labetalol IV (medication for blood pressure given intravenously). [space] 10/31/23 23:00:55.....I reviewed CT scan ...... Showing left basal ganglia hemorrhage (hemorrhagic [bleed] stroke in a part of the brain] .... I did discuss the patient with the neurologist, who accepts the patient in transfer for treatment of acute atraumatic hemorrhage. The patient did receive a dose of labetalol, and her blood pressure dropped below 160 briefly but then went back up over 170, so nicardipine infusion was started. Diagnosis/Disposition Acute atraumatic intraparenchymal hemorrhage (bleeding into the brain) [space] Acute hypertensive emergency (acute marked elevation in BP associated with signs of damage) [space] Right-sided weakness. ...." Review of the Transfer Form revealed Patient #1 was accepted for transfer at 2225. Review of the Physician's Certification for Medical Transport form revealed " ...Medical Condition at the Time of Transport : Patient requires neurological, cardiac, and hemodynamic monitoring and a nicardipine drip by a medical attendant throughout transport......." Review revealed Patient #1 was transferred out at 2233 as a "Red" priority. Review of the EMS Patient Care Record revealed EMS transferred Patient #1 as an emergency "red" transfer. Review of the "Narrative" documentation revealed "(EMS) WAS ISSUED A RED TRANSPORT TO (Hospital A). ..... THE PT WAS BEING TRANSPORTED TO (Hospital A) DUE TO INTRACRANIAL HEMORRHAGE. THE PT WAS PLACED ON THE CARDIAC MONITOR, 12 LEAD ESTABLISHED .... THE	{A1101}		

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MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 287 PHYSICIAN ADVISED TARGET BLOOD PRESSURE IS 140/90 AND ADVISED TO MONITOR BLOOD PRESSURE DURING TRANSPORT. NICARDIPINE WAS ADMINISTERED AND MAINTAINED THROUGHOUT ROUTE..... EMERGENCY TRAFFIC. THE PT WAS REASSESSED EVERY 5 MINUTES DURING TRANSPORT.... PT REMAINED ALERT, ORIENTED, SLURRED SPEECH WAS NOTED. PT CARE.......UPON ARRIVAL, THE PT WAS REGISTERED, AND EMS WAITED ON ROOM ASSIGNMENTS. VITAL SIGNS WERE CONTINUOUSLY MONITORED. A PHYSICIAN STATED, 'WHAT DO YOU HAVE?'. THE PHYSICAN (sic) WAS ADVISED RED TRANSPORT FROM (Hospital B) ER TO (Hospital A) WITH AN INTRACRANIAL HEMORRHAGE. THE PHYSICIAN ASKED FOR PAPERWORK AND THEN STATED 'NEVER MIND.' THE PT REMAINED STABLE WITH ONLY COMPLIANT (sic) OF A HEADACHE. THE NEUROLOGIST (Name of accepting physician) ADVISED THE PT WOULD MOVE TO THE ICU ONCE A BED WAS AVAILABLE. THE PT REMAINED IN THE HALLWAY AND WAS CONTINUOUSLY MONITORED AND ASSESSED. (EMS) WAS ADVISED THE PT WOULD BE TRANSFERRED TO THE NEUROLOGY ICU. PT CARE REPORT WAS GIVEN TO THE ATTENDING NURSE..... PT CARE WAS TRANSFERRED..." Review revealed the EMS unit arrived to Hospital A at 2312 and Patient #1's care was handed-off to hospital staff at 0106 (1 hour 54 minutes after arrival to the hospital). Review revealed EMS completed vital signs every 5 minutes to 10 minutes throughout the wait time for a bed and hand-off to the hospital.	{A1101}		

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{A1101}	Continued From page 288 Review of the Hospital A medical record for Patient #1 revealed the patient arrived as a transfer via EMS at 2314. Review of the "ED Report" by an ED physician, at 2351, revealed " ... 64-year-old female who presents as a transfer due to intracranial hemorrhage. Was taken to an outside hospital due to concern unilateral (one-sided) weakness and speech difficulty at roughly 2130. At that time had a head CT which showed an intracranial bleed and thus the patient was transferred here. At the outside hospital she was noted to have fairly profound hypertension was given IV Lopressor (treats elevated BP). Plan is for neurology admission however they would like angiography of the head and neck prior to getting a bed. Nicardipine was also initiated for blood pressure management.....Physical Exam .... Initial Vitals No Data Available .... Neuro: Right-sided facial droop with loss of nasolabial fold as well as dysarthria noted. Weakness of the right arm over relatively normal left arm and lower extremities. Medical Decision Making ..... Patient presents as a transfer due to intracranial hemorrhage. Working with nursing staff in order to have this patient placed in a room. Neurology is already consulted on this patient, will follow-up with their requested CT angiography. We will also needs (sic) very close blood pressure monitoring. ..." Review also revealed a Neurology "History and Physical", service date/time 10/31/2023 2347, which indicated "....Impression and Plan: ... #ICH (Intracranial Hemorrhage): hypertensive etiology suspected..... #HTN (hypertension) urgency: no prior hx (history) of HTN, treat >160/90 with goal towards normotension. #dysarthria, right hemiparesis (weakness or partial paralysis on one side of the body). Plan: admit to ICU for close neurologic monitoring. ....." Review of the ED record failed to reveal any vital	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 289	{A1101}		

signs or assessments by nursing. Review revealed "Nurse Notes" on 11/01/2023 at 0051 that stated "RN gave heads up to NSICU (Neurosurgery ICU) by (Name), RN. ED CNC (Clinical Nurse Coordinator) aware that (Name), RN is not assuming care of patient and only transporting PT (patient) upstairs. Pt has been with EMS in hallway for approx. (approximately) 2 hours and now has bed assignment upstairs. RN only transporting from EMS to NSICU." Record review failed to reveal an ED RN ever accepted, triaged, assessed or did vital signs on Patient #1 while the patient was in the Emergency Department. The first documented vital signs were at 0110, once Patient #1 arrived to NSICU. The patient's blood pressure at 0110 was documented as 162/85.

Telephone interview with EMS #73 on 11/30/2023 at 1415 revealed the paramedic was involved in the transfer of Patient #1. Interview revealed it was a "red" transfer. Interview revealed on arrival to the hospital they gave the paperwork to hospital staff and then "sat on the wall." The neurologist came to evaluate the patient and said she would move as soon as a bed was available. EMS, interview revealed, continue to monitor Patient #1. The patient was on IV medications for blood pressure and EMS staff had to "fluctuate the meds to keep the blood pressure where it needed to be." Interview revealed no nurse evaluated Patient #1 while she was in the ED.

Interview with MD #69 the accepting neurologist, revealed it was not uncommon to do ED to ED transfers, that it was good to have them in the ED for emergent evaluation when there was a concern for a patient's stability on arrival. Interview revealed MD # 69 came to see patients

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{A1101}	Continued From page 290 in the ED as soon as they were notified of the patient's arrival. Interview revealed it was "surprising" not to have vital signs completed in the ED and stated it did not meet expectations for care - patients needed hourly neuro checks and vital signs with provider updates on changes. Interview with RN #64 during observation 11/13/2023 around 1030 revealed that when EMS arrives with patients and there are no beds available then EMS stays "on the wall" with the patient until a bed is available. They do not hand-off the patient until patients get to an assigned bed. Physicians may see patients on the wall, but "EMS can only hand-off to a RN." Follow-up telephone interview on 11/15/2023 at 1430 revealed that in relation to patients arriving with EMS, ED nurses do not "triage patients until ...taking ownership of the patient. Interview revealed that if the CNC in the EMS arrival area was to triage the patient, then the RN was "taking ownership of the patient." The RN stated they could not do that as CNC and still meet all the expectations of the role. Interview revealed that in this ED, "EMS is still responsible." Telephone interview with RN #66, on 11/17/2023 at 0932, revealed the EMS team was responsible for any patients they brought in until a room was assigned and the patient moved to a room in the ED. Once the patient was in a room, the ED RN triaged the patient and there was a proper hand-off between EMS and the RN. Patient #1 arrived as a transfer on 10/31/2023 at 2314 by EMS. No triage, nursing assessment or evaluation was completed in the ED. The patient was transported to the NSICU (Neurosciences Intensive Care Unit) on 11/01/2023 at 0105. A	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 291 nursing note was written that stated the nurse was only transporting the patient to the inpatient unit and had not assumed care of the patient. The first nursing vitals or assessment were done at 0110 in NSICU. EMS monitored Patient #1 in the ED and nursing failed to accept, triage and provide care to a patient in the ED. 9. Review of the EMS Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The EMS record revealed the call came in at 1654, EMS reached the patient at 1702, departed the scene at 1720 and reached the Hospital at 1748. The Patient Care Record noted the patient's medical history was "Cirrhosis of Liver, Diabetes, Infectious disease, Neuropathy, Other-Infection of foot - amputation schedule for 10/21." Review of the Narrative Note revealed "(EMS) DISPATCHED EMERGENCY TRAFFIC TO LISTED ADDRESS REFERENCE SYNCOPAL EPISODE WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED ON SCENT TO FIND A 66-YEAR-OLD MALE, A&Ox4, SKIN PALE, WARM, AND DRY, SITTING UPRIGHT IN A RECLINER IN THE LIVING ROOM. PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK ....ADMINISTERED ASPIRIN ...PT ADVISED THAT HE AND HIS FRIEND HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT. PT'S FRIEND ADVISED PT DID NOT FALL, 'I CAUGHT HIM ON THE WAY DOWN.'......PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT HAD GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY TO REMOVE THE	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101}	Continued From page 292 BIG TOE OF HIS LEFT FOOT. IT WAS NOW NOTED THAT PT'S EKG WAS SHOWING ....ALSO SHORT RUNS OF A WIDE COMPLEX TACHYCARDIA. PT REMAINED COMPLETELY A&Ox4 PT WAS PLACED ON SUPPLEMENTAL OXYGEN WITH NOTED IMPROVEMENT IN BREATHING, ACCORDING TO THE PT. PT WAS TRANSPORTED ROUTINE TRAFFIC TO (Hospital) ..... WHILE ENROUTE PT'S VITALS WERE CONTINUALLY ASSESSED ...IV ACCESS WAS OBTAINED ... PT WAS FOUND TO HYPERGLYCEMIC (high blood sugar). PT ADVISED HE HAD NOT BEEN ABLE TO TAKE HIS INSULIN YET TODAY PT WAS ADMINISTERED FLUID AS RECORDED PT ADVISED HIS CHEST PAIN WAS A 6/10 AND THAT TAKING A DEEP BREATH HURT. PT ADVISED THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED. (Hospital) WAS CONTACTED FOR PT NOTIFICATION. UPON ARRIVAL AT (Hospital) PT WAS TAKEN TO ER ROOM, WHERE (EMS) WAITED FOR ER PERSONNEL TO COME FOR THE HANDOFF REPORT WHILE BEING CONTINUALLY MONITORED. A FACILITY RN FINALLY ARRIVED AND A FULL REPORT WAS GIVEN AND PT CARE WAS TRANSFERRED TO THE RECEIVING RN. ....." EMS record review revealed the team arrived to the hospital with Patient #2 at 1748 and care was transferred to hospital staff at 1907 (1 hour, 19 minutes after arrival). Review revealed EMS staff continued monitoring Patient #2 after arrival with vital signs generally taken every 5-6 minutes. The last recorded EMS vital signs were at 1858 with BP noted as 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. A note was made on "Turn Around Delays" that indicated "ED Overcrowding/ Transfer of Care ......"	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101} Continued From page 293 {A1101}

Review of the medical record, on 11/14/2023, revealed Patient #2 arrived to the hospital on 10/17/2023 at 1753 via EMS. Review of "ED Triage", performed 10/17/2023, at 1900 (1 hour and 7 minutes after arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were: Temperature 97.9, Pulse 72, Respirations 20, blood pressure 106/69 and oxygen saturation of 100% on 4 liters oxygen. Patient #2's pain score was 7.

Review of the "ER Report" by a Physician Assistant, on 10/17/2023 at 1845, revealed " ... 66-year-old male patient .... presents..... (to the) emergency department today via EMS for chief complaint of chest pain and shortness of breath. Patient reports that he has had chest pain and shortness of breath ongoing over the past week and reports that these symptoms are aggravated with exertion. He also reports aggravation to shortness of breath with lying supine and he states that today he had acute worsening to his symptoms and also had a syncopal episode earlier today. He reports pain and shortness of breath are still present. He states that he also has bilateral lower extremity swelling which has been ongoing over the past couple of weeks .....He states that he has ulcer to the first metatarsal of his left foot and this extends to his bone. He states that he has planned to have amputation of the first digit of his left foot this coming Friday patient currently taking ciprofloxacin (antibiotic , Diflucan (antifungal), and Duricef (antibiotic). ....Medical Decision Making...... EMS reports that they gave patient 324 mg aspirin...... blood pressure was approximately 96 mmHg. They gave one L (liter) of normal saline IV blood pressure is 105/66 now. EMS also reports that

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A1101}	Continued From page 294 patient had 7 beat run of V tach on their EKG tracing in route with patient now in sinus rhythm and occasional bigeminy. Ordered EKG and for patient to be on telemetry .....Point-of-care CBG (blood sugar), CMP (comprehensive metabolic panel), CBC (complete blood count), troponin, proBNP, D-dimer, lactic acid, and portable 1 view chest x-ray ordered. EKG obtained and notes sinus rhythm with PVCs and 4 beat run of V tach ... 1953 Dr. (Name) called to patients bedside for cardiac arrest and assumed care of patient. CPR initiated ....2017..... Called lab torequest results of chemistries be available as soon as possible. Labs resulted after arrest .... Resuscitation attempt failed. Patient deceased. Suspect etiology to cardiac arrest related to MI (Myocardial infarction- heart attack). Review revealed a Stat order for an EKG at 1841. Review did not reveal an EKG was completed until 1905 (24 minutes after ordered and 1 hour and 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered in the ED stat at 1841 (48 minutes after Patient #2 arrived): Lactic Acid, CMP (comprehensive metabolic panel), Troponin, D-Dimer, Pro B-Type Natriuretic Peptide (ProBNP) and CBC with Differential. Review of orders revealed the labs were collected as Nurse collects at 1920 (39 minutes after the lab orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The CBC resulted at 2002 and the CMP resulted at 2012. The D-Dimer resulted as 824 (high) at 2006. The Pro BNP resulted as 9690 (High - reference range 5-125) at 2023 and the Troponin resulted as 0.460 (High - reference range 0.000-0.034) at 2039 (1 hour 19 minutes after the lab was collected; 1 hour, 58 minutes after it was ordered). The physician was notified.	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 295 Review revealed the physician was notified 2 hours, 46 minutes after Patient #2 arrived to the ED and 15 minutes after the patient expired). Review revealed delays in ordering, collecting and resulting the labs and a delay in obtaining an EKG. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed " ...The patient was initially evaluated by the emergency department physician assistant......Work-up for chest pain and syncope were underway. I was called to the patient's bedside at 1953 for cardiac arrest. Staff reports that only moments before the patient had been alert and talking. CPR (cardia pulmonary resuscitation) was initiated. The patient was placed on a monitor and defibrillator. Initial rhythm revealed ventricular tachycardia (fast heart rhythm). He received electrical therapy and CPR was resumed. Patient received high-quality chest compressions. He would briefly show signs consciousness indicating adequate cerebral perfusion (blood to the brain) with chest compressions, but remained without an organized rhythm .....required continuation of CPR. He received multiple doses of electrical therapy......He received magnesium as well as amiodarone (medication for irregular heart rhythm) for shock refractory ventricular tachycardia. Ventricular tachycardia progressed to ventricular fibrillation (life threatening arrhythmia). He also received multiple doses of epinephrine (emergency medication) per ACLS (advanced cardiac life support) protocol for pulseless arrest. He was intubated.....I called the physician assistant to the bedside to brief me on the details of the initial presentation. During the resuscitation I took the opportunity to review the available work-up. The EKG was brought to me for review at 2002 .....For	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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{A1101}	Continued From page 296 this patient who presented with chest pain, syncope, and suffered cardiac arrest has either suffered an MI or rhythm disturbance.....I reviewed his medications..... I made attempts to address.....reversible causes of cardiac arrest. As resuscitation proceeded the rhythm progressed ....to asystole.....After 30 minutes of resuscitation he remained in asystole. All team members agreed that further resuscitative efforts were futile ... the patient was pronounced dead at 8:24 PM ... 10/17/23 20:38:56 I received a (sic) from the chemistry lab. Troponin is 0.46 ... Diagnosis/Disposition Chest pain Syncope Ventricular tachycardia Cardiopulmonary arrest...." Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed they responded to a call for a patient with chest pain and shortness of breath. Interview revealed on EKG the heart was very irritated, throwing PVCs (arrhythmias), PACs (arrhythmias) and then short runs of wide complex tachycardia (rapid heart rate). Interview revealed there was potential for things to turn unstable quickly. By the time they got to the hospital there were just a few PVCs. EMS #70 stated they arrived to the hospital at 1750 and were assigned a room at 1756 but they got to the room and there was a patient in the room which caused the wait. EMS #70 stated at some point the patient started to get hypotensive and the fluids had emptied, so the other EMS staff gathered another bag of fluids. Patient #2, per EMS, was on supplemental oxygen and had no complaints at the time. Interview revealed they got the patient into an ED bed at 1845 but there was no nurse for report. At 1907 (1 hours, 17 minutes after arrival), per interview, EMS was able to give hand-off report to a nurse. Interview revealed waits had gotten more common recently	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 297 and it seemed like a staffing issue. Telephone interview with PA #71, on 11/15/2023 at 1600, revealed the patient came into the ED with EMS and there were no rooms available. PA #71 stated he saw the patient while in the hallway and placed orders. Interview revealed the patient had not been triaged, he was still in the hall. Interview revealed prior to arrival the patient had "a few runs, approximately 8 beats", of V tach. PA #71 stated the patient was given a liter of fluids and the rhythm improved. Patient #2 remained on the EMS monitor prior to getting a formal EKG in the ED, the PA stated. Interview revealed there were another 4 beats of V tach but it was not sustained; the patient appeared stable. PA #71 moved to another patient and did not see Patient #2 after he got in an ED room until the PA heard the code and responded. Interview revealed these patients should be closely monitored. Interview revealed the goal for the screening evaluation was 20 minutes from arrival. Telephone interview with RN #66, on 11/16/2023 at 0938, revealed the nurse assigned to Patient #2's room was busy and not able to triage the patient, so a radio request for help was made and RN #66 responded, did the hand-off with EMS and triaged Patient #2. The patient had been placed on a monitor by the Certified Nursing Assistant (CNA). RN #66 then received report from EMS. Interview revealed there was no bed available when Patient #2 first arrived by EMS. When RN #66 went to triage the patient, Patient #2 had just been put in a room and was stable, alert and talking. RN #66 stated that after Patient #2 was triaged, RN #66 drew blood for labs; labs were not drawn until after the patient was accepted and in a room. Until the patients were in	{A1101}		

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	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	**509 BILTMORE AVE ASHEVILLE, NC 28801**

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{A1101}	Continued From page 298	{A1101}		

a room and care handed-off from EMS, interview revealed, they were "counting on EMS to care for (the patients)..."

Telephone interview on 11/16/2023 at 1100 with MD #72 revealed he heard the overhead page for Patient #2 and immediately responded. Interview revealed the expectation for chest pain patients was an EKG within 10 minutes and to be seen by a provider within 10 minutes. Interview revealed there is a chest pain protocol but the protocol had to be activated by a provider. MD #72 acknowledged there was a delay for Patient #2. Interview revealed in an ideal situation the patient would have gone straight back to a room and care started.

Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain and a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived), and the labs were not collected by nursing staff until 1920 (39 minutes after orders), after the patient was triaged at 1900 (1 hour and 7 minutes after arrival). The patient was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (24 minutes after order and 1 hour 12 minutes after arrival). The elevated D-Dimer did not result until 2006, the elevated Pro BNP did not result until 2023 and the elevated Troponin did not result until 2039. At 1953 a physician responded to the patient's bedside due to a cardiac arrest. CPR was started and the patient expired. Nursing staff failed to accept the patient upon arrival to the ED, resulting in delayed triage, care and treatment.
10. Closed medical record review of Patient #12 revealed a 41 year old female transferred to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

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{A1101}	Continued From page 299 ED (emergency department) on 07/18/2023 at 1623 via EMS (emergency medical service) for abdominal pain, nausea, chills, and evaluation by general surgery for concerns of appendicitis. No past medical history. Review of EMS run report revealed vital signs were taken at 1526 and 1555 via EMS. Review of ED record revealed a Medical Screening Examination (MSE) was performed at 1653. Further review of MSE revealed the CT (computed tomography) was consistent with appendicitis and general surgery consult placed at 1652. Review of physician orders revealed an order for q4h (every 4 hours) vital signs at 1729. An order for Dilaudid 0.25mg (milligram) Inj. Q3h, PRN (as needed), pain (refractory) at 1729. An order for Dilaudid 0.5mg Inj. Q15min, PRN, pain, at 1734. Review of ED record revealed the patient was assigned to RPOD-Hall 18 at 1756. Review of ED record revealed a pain assessment of 10 at 1759. Review of MAR (medication administration record) revealed the patient was given Zofran 4mg at 1757 and Dilaudid 0.5mg at 1759. Review of the General Surgery History and Physical at 1820 revealed a plan to proceed with laparoscopic appendectomy. Pain control and antiemetics as needed. Review of ED record revealed the patient was transferred to preop at 1830. Review of ED record revealed triage time at 1832 and vital signs documented at 1832 (2 hours and 9 minutes after the patient's arrival). Interview on 11/14/2023 at 1153 with RN #91 revealed when patients are "on the wall" they are waiting to be assigned an RN (registered nurse) and put in a room. EMS stays with the patient in case they need any medical attention. Interview revealed it is typically not a long wait but can be up to an hour. Interview revealed patients can be seen by providers and prescribed medications	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

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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) COMPLETION DATE
{A1101}	Continued From page 300 while "on the wall" but can not get them because no RN has been assigned. 11. Review on 11/16/2023 of "Nursing Management of Wounds and Alterations of Skin" policy revised 11/2021 revealed, "POLICY: Patients are assessed on admission and once every 12-hour shift for alterations in skin integrity and/or wounds. SCOPE:...Inpatient, acute care services, critical access hospitals, and other related services. Emergency Department (ED)...DOCUMENTATION: Document wound details: type, bed color, odor, drainage (color and amount), undermining/tunneling, induration, and erythema. Document intervention". Review on 11/16/2023 of the "Assessment and Reassessment" policy revised 06/2021 revealed: "...PURPOSE: A. The goal of the assessment/reassessment is to provide the patient the best care and treatment possible...The nursing process is utilized in order to achieve this goal. This process includes assessing, analyzing, planning, implementing, and evaluating patient care or treatment...". Closed medical record review on 11/14/23 of Patient #26 revealed a 22-year-old patient that presented to the Emergency Department (ED) via EMS (Emergency Management Services) on 09/01/2022 at 1845 for complaints of abdominal pain, decreased appetite, watery non-bloody diarrhea, and right-calf burn. Review of an ED Note dated 09/01/2022 at 2130 per medical provider indicated: "Assessment/Plan...Burn. I ordered bacitracin and instructed the nurse to apply a Xeroform dressing". Review of Patient #26's closed medical record lacked documentation that an ED nurse assessed and	{A1101}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340002	A. BUILDING ______ B. WING ______	R-C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL MISSION HOSPITAL AND ASHEVILLE SURGERY CE	509 BILTMORE AVE ASHEVILLE, NC 28801

(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) COMPLETION DATE
{A1101}	Continued From page 301 applied bacitracin and a Xeroform dressing to the patient's right-calf burn. Review revealed the patient was transferred to inpatient room #566 A5-West on 09/03/2022 at 1357. Review revealed a nursing wound consultation was completed on 09/04/2022 at 1024. Review of Inpatient Wound/Ostomy Documentation Note dated 09/04/2022 at 1024 indicated: "Wound care consult received for calf burn...wound is pink, red wound bed, superficial. Communicated with RN (Registered Nurse) that wound team will not be able to prioritize this patient today. Would recommend provider place order for bacitracin to be applied generously, cover with xeroform gauze, then dry gauze and gauze roll, daily. Will only follow if wound worsend with appropriate treament-please reconsult if this occurs". Review of a physician's order dated 09/04/2022 at 2100 indicated: "Bactroban topical 2% cream to be applied three times daily at 0900, 1500, and 2100 for 7 days to right-calf wound". Record review revealed a lack of documentation related to the application of the aforementioned wound treatment per nursing. Review of the patient's closed medical record lacked nursing documentation related to the assessment and treatment of the patient's right calf wound from presentation in the ED on 09/01/2022 through discharge on 09/07/2022.	{A1101}		

Attachment 3:

Blue Ridge Regional Hospital Survey Documentation

Acute and Home Care Licensure and Certification Section

(Hospitals, ASFs, Home Health Agencies, Hospice Home Care, Inpatient and Residential Facilities, and Psychiatric Hospitals or Substance Abuse Facilities licensed pursuant to 10A NCAC 27G .6000)

DATE: September 1, 2023

TO: Azzie Conley, Chief, Acute and Home Care Licensure & Certification Section

FROM: Tanya M. Saporito, Project Analyst, HPCON 5-3886

CON Project ID #	B-12380-23	FID #	220170	County	Buncombe
Name of Facility	Mission Hospital				
Applicant 1	MH Mission Hospital, LLLP				
Applicant 2	NA				
Project Description	Develop a freestanding emergency department in west Asheville licensed under Mission Hospital				

Please complete the following table ***with any updated information since July 1, 2023*** and return to the Analyst named above. *Thank you!*

Facility Name	Facility Street Address	FID	(1) In Compliance (Yes or No)	(2) Survey Date	(3) Back in Compliance Date
McDowell Hospital	430 Rankin Drive, Marion	943492	Yes		
Angel Medical Center	120 Riverview Street, Franklin	942938	Yes		
Highlands-Cashiers Hospital	190 Hospital Drive, Highlands	943256	Yes		
Blue Ridge Regional Hospital	125 Hospital Drive, Spruce Pine	953466	No	07/13/23	
Transylvania Regional Hospital	260 Hospital Drive, Brevard	923509	No	3/17/23	5/24/23

Instructions for Columns (1), (2) and (3):

(1) Has each facility named above met all Medicare Conditions of Participation (if Medicare Certified) between January 2022 and today's date?

If yes, place "yes" in Column (1), sign the form and return it to the analyst.

If no, place "no" in Column (1) and fill in Columns (2) and (3).

(2) Provide the date of the survey which resulted in a determination of noncompliance with a Condition of Participation in Column (2). If there are multiple surveys for the same facility, please list each survey on a separate line in the table.

(3) If the Conditions of Participation have since been corrected and the facility is now in compliance, place the date that the facility was found to be back in compliance in Column (3).

If the Conditions of Participation have not been corrected and the facility is not in compliance, leave Column (3) blank.

Please sign the form below and return to the analyst.
Thank you.

Michelle Cooke, RN	(919) 208-1630	September 20, 2023
Surveyor's Name	Phone #	Date

Attachment 4:
Excerpts from Agency Findings from 2011 Wake County Nursing Home Review

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: January 27, 2012
FINDINGS DATE: February 3, 2012
PROJECT ANALYST: Michael J. McKillip
ASSISTANT CHIEF: Martha J. Frisone

PROJECT I.D. NUMBERS:

J-8711-11 / Hillcrest Convalescent Center, Inc. / Develop a 120-bed nursing facility in Wake Forest / Wake County **(Hillcrest-Wake Forest)**

J-8712-11 / Wake County H & R Re, Limited Partnership (lessor), Wake County H & R Ops, Limited Partnership (lessee), Medical Facilities of North Carolina, Inc. and Medical Facilities of America, Inc. / Develop a 120-bed nursing facility in Cary / Wake County **(Wake Health & Rehab-Cary)**

J-8713-11 / Britthaven, Inc. (lessor) and Spruce LTC Group, LLC (lessee) / Develop a 120-bed nursing facility in the Brier Creek area / Wake County **(Britthaven-Brier Creek)**

J-8714-11 / Universal Properties/North Raleigh, LLC (lessor) and Universal Health Care/North Raleigh, Inc. (lessee) / Develop 20 additional nursing beds at an existing North Raleigh facility for a total of 132 nursing facility beds and 20 adult care home beds upon completion / Wake County **(Universal-North Raleigh)**

J-8715-11 / Britthaven, Inc. (lessor) and Redwood LTC Group, LLC (lessee) / Develop a 100-bed nursing facility in Garner / Wake County **(Britthaven-Garner)**

J-8717-11 / AH North Carolina Owner, LLC / Develop a 90-bed nursing facility in North Raleigh / Wake County **(Brookdale-North Raleigh)**

J-8719-11 / UniHealth Post-Acute Care-Raleigh, LLC and Wake Health Properties, Inc. / Develop 20 additional nursing beds at an existing 150-bed Raleigh facility for a total of 170 nursing facility beds upon completion / Wake County **(UniHealth-Raleigh)**

J-8720-11 / UniHealth Post-Acute Care-Cary, LLC and Cary Healthcare Properties, Inc. / Develop a 100-bed nursing facility in Morrisville / Wake County **(UniHealth-Cary)**

J-8721-11 / Universal Properties/Fuquay Varina, LLC (lessor) and Universal Health Care/Fuquay Varina, Inc. (lessee) / Develop 60 additional nursing beds at an existing Fuquay Varina facility for a total of 109 nursing facility beds and 31 adult care home beds upon completion / Wake County **(Universal-Fuquay Varina)**

J-8722-11 / UniHealth Post-Acute Care-North Raleigh, LLC and North Raleigh Healthcare Properties, Inc. / Develop a 120-bed nursing facility in the Brier Creek area / Wake County **(UniHealth-North Raleigh)**

J-8723-11 / Liberty Healthcare Properties of West Wake County, LLC; Liberty Commons Nursing and Rehabilitation Center of West Wake County, LLC; Liberty Healthcare Properties of Wake County, LLC; and Liberty Commons Nursing and Rehabilitation Center of Wake County, LLC / Develop a 130-bed nursing facility in Garner with 120 new nursing facility beds and 10 nursing facility beds to be relocated from Capital Nursing / Wake County **(Liberty-Garner)**

J-8726-11 / Liberty Healthcare Properties of West Wake County, LLC; Liberty Commons Nursing and Rehabilitation Center of West Wake County, LLC; Liberty Healthcare Properties of Wake County, LLC; and Liberty Commons Nursing and Rehabilitation Center of Wake County, LLC / Develop a 130-bed nursing facility in Morrisville with 120 new nursing facility beds and 10 nursing facility beds to be relocated from Capital Nursing / Wake County **(Liberty-Morrisville)**

J-8727-11 / Liberty Healthcare Properties of West Wake County, LLC; Liberty Commons Nursing and Rehabilitation Center of West Wake County, LLC; Liberty Healthcare Properties of Wake County, LLC; and Liberty Commons Nursing and Rehabilitation Center of Wake County, LLC / Develop a 130-bed nursing facility in North Raleigh with 120 new nursing facility beds and 10 nursing facility beds to be relocated from Capital Nursing / Wake County **(Liberty-North Raleigh)**

J-8729-11 / E.N.W., LLC (lessor) and BellaRose Nursing and Rehab Center, Inc. (lessee) / Develop a 100-bed nursing facility on Rock Quarry Road in Raleigh / Wake County **(BellaRose-Raleigh)**

J-8730-11 / Cary Operations, LLC d/b/a The Rehabilitation and Nursing Center at Cary / Develop a 120-bed nursing facility in Cary / Wake County **(Rehab & Nursing Center-Cary)**

J-8731-11 / Raleigh Operations, LLC d/b/a The Rehabilitation and Nursing Center at Raleigh / Develop a 120-bed nursing facility in Raleigh / Wake County **(Rehab & Nursing Center-Raleigh)**

provide adequate access to medically underserved groups. See Criterion (13a) for additional discussion. Also, the applicant did not demonstrate that medically underserved groups will have adequate access to the proposed services. See Criterion (13c) for additional discussion. Therefore, the application is not conforming to this criterion.

Rehab & Nursing Center-Raleigh. See Sections II, III, VI, VIII and XI.13-14. However, the applicant did not adequately demonstrate that its proposal to develop a 120-bed nursing facility in Raleigh would have a positive impact on cost-effectiveness of the proposed services. The applicant did not adequately demonstrate that the proposed project is financially feasible and is based on reasonable projections of costs and charges for the type of facility proposed. See Criterion (5) for additional discussion. Also, in Section I.12, page 9, the applicant states that one of its *"affiliated entities"* operates Blue Ridge Health Care Center, which is located in Wake County. The applicant did not demonstrate that they currently provide adequate access to medically underserved groups. See Criterion (13a) for additional discussion. Also, the applicant did not demonstrate that medically underserved groups will have adequate access to the proposed services. See Criterion (13c) for additional discussion. Therefore, the application is not conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

NA
Hillcrest-Wake Forest
Wake Health & Rehab-Cary
Brookdale-North Raleigh

NC
Liberty-Garner
Liberty-Morrisville
Liberty-North Raleigh

C
All Others

Britthaven-Brier Creek. In Section I.12, page 13, the applicants, Britthaven, Inc. (lessor) and Spruce LTC Group, LLC (lessee), state that Spruce LTC Group, LLC is a subsidiary of Principle Long Term Care, Inc., which is the manager of Tower Nursing and Rehab Center. Tower Nursing and Rehab Center (formerly City of Oaks Health and Rehabilitation Center) is an existing nursing facility in Wake County with 180 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Tower Nursing and Rehab Center for which licensure penalties, suspension of admissions, provisional licensure, or

certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Universal-North Raleigh. Universal-North Raleigh is an existing nursing facility in Wake County with 112 nursing care beds. Also, the applicants identify Choice Healthcare Management Services, LLC as the management company for the facility. In Section I.12, pages 8-9, the applicants provide a list of nursing facilities managed by Choice Healthcare Management Services, LLC in North Carolina, including Litchford Falls Healthcare and Rehab Center. Litchford Falls Healthcare and Rehab Center is an existing nursing facility in Wake County with 90 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Litchford Falls Healthcare and Rehab Center or Universal Healthcare-North Raleigh for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Britthaven-Garner. In Section I.12, page 13, the applicants, Britthaven, Inc. (lessor) and Redwood LTC Group, LLC (lessee), state that Redwood LTC Group, LLC is a subsidiary of Principle Long Term Care, Inc., which is the manager of Tower Nursing and Rehab Center. Tower Nursing and Rehab Center (formerly City of Oaks Health and Rehabilitation Center) is an existing nursing facility in Wake County with 180 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Tower Nursing and Rehab Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

UniHealth-Raleigh. UniHealth-Raleigh is an existing nursing facility in Wake County with 150 nursing care beds. In Exhibit 6, the applicant provides a list of nursing facilities in North Carolina operated by UHS-Pruitt Corporation, including The Oaks at Mayview (Mayview Convalescent Center). Mayview Convalescent Center is an existing nursing facility in Wake County with 139 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at UniHealth-Raleigh or Mayview Convalescent Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

UniHealth-Cary. In Section I.12, pages 16-17, the applicants, UniHealth Post-Acute Care-Cary, LLC and Cary Healthcare Properties, Inc., identify United Health Services, Inc. (UHS) as the parent company for UniHealth-Cary, and UHS-Pruitt Corporation as the management company. In Exhibit 6, the applicant provides a list of nursing facilities in North Carolina operated by UHS-Pruitt Corporation, including UniHealth Post-Acute Care-Raleigh and The Oaks at Mayview (Mayview Convalescent Center). UniHealth Post-Acute Care-Raleigh is an existing nursing facility in Wake County with 150 nursing care beds. Mayview Convalescent Center is an existing nursing facility in Wake County with 139 nursing care beds. According to

the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at UniHealth Post-Acute Care-Raleigh or Mayview Convalescent Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Universal-Fuquay Varina. Universal Healthcare-Fuquay Varina is an approved, but not yet developed, Wake County replacement nursing facility with 49 nursing care beds and 31 adult care home beds. In Section I.9, page 6, the applicants, Universal Properties/Fuquay Varina, LLC (lessor) and Universal Health Care/Fuquay Varina, Inc. (lessee), identify Choice Healthcare Management Services, LLC as the management company for the facility. In Section I.12, pages 8-9, the applicants provide a list of nursing facilities managed by Choice Healthcare Management Services, LLC in North Carolina, including Litchford Falls Healthcare and Rehab Center and Universal Healthcare-North Raleigh. Litchford Falls Healthcare and Rehab Center is an existing nursing facility in Wake County with 90 nursing care beds, and Universal Healthcare-North Raleigh is an existing nursing facility in Wake County with 112 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Litchford Falls Healthcare and Rehab Center or Universal Healthcare-North Raleigh for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

UniHealth-North Raleigh. In Section I.12, pages 16-17, the applicants, UniHealth Post-Acute Care-North Raleigh, LLC and North Raleigh Healthcare Properties, Inc., identify United Health Services, Inc. (UHS) as the parent company for UniHealth-Cary, and UHS-Pruitt Corporation as the management company. In Exhibit 6, the applicant provides a list of nursing facilities in North Carolina operated by UHS-Pruitt Corporation, including UniHealth Post-Acute Care-Raleigh and The Oaks at Mayview (Mayview Convalescent Center). UniHealth Post-Acute Care-Raleigh is an existing nursing facility in Wake County with 150 nursing care beds. Mayview Convalescent Center is an existing nursing facility in Wake County with 139 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at UniHealth Post-Acute Care-Raleigh or Mayview Convalescent Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Liberty-Garner. In Section I.12(a), page 18, the applicants provide a list of nursing facilities they own or operate in North Carolina, including Capital Nursing and Rehabilitation Center in Raleigh. Capital Nursing and Rehabilitation Center is an existing nursing facility in Wake County with 125 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, Capital Nursing and Rehabilitation Center had certification deficiencies constituting

substandard quality of care, including immediate jeopardy to resident health or safety. Therefore, the application is not conforming to this criterion.

Liberty-Morrisville. In Section I.12(a), page 18, the applicants provide a list of nursing facilities they own or operate in North Carolina, including Capital Nursing and Rehabilitation Center in Raleigh. Capital Nursing and Rehabilitation Center is an existing nursing facility in Wake County with 125 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, Capital Nursing and Rehabilitation Center had certification deficiencies constituting substandard quality of care, including immediate jeopardy to resident health or safety. Therefore, the application is not conforming to this criterion.

Liberty-North Raleigh. In Section I.12(a), page 18, the applicants provide a list of nursing facilities they own or operate in North Carolina, including Capital Nursing and Rehabilitation Center in Raleigh. Capital Nursing and Rehabilitation Center is an existing nursing facility in Wake County with 125 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, Capital Nursing and Rehabilitation Center had certification deficiencies constituting substandard quality of care, including immediate jeopardy to resident health or safety. Therefore, the application is not conforming to this criterion.

BellaRose-Raleigh. On page 15, the applicants state that four of the *"principals"* in the applicant companies, E.N.W., LLC (lessor) and BellaRose Nursing and Rehab Center, Inc. (lessee), hold ownership interests in other nursing facilities in North Carolina, including Hillside Nursing Center of Wake Forest and Windsor Point in Fuquay Varina, which are located in Wake County. Hillside Nursing Center of Wake Forest is an existing nursing facility in Wake County with 130 nursing care beds. Windsor Point is an existing nursing facility in Wake County with 45 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Hillside Nursing Center of Wake Forest or Windsor Point for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Rehab & Nursing Center-Cary. In Section I.12, page 9, the applicant states that one of its *"affiliated entities"* operates Blue Ridge Health Care Center, which is located in Wake County. Blue Ridge Health Care Center is an existing nursing facility in Wake County with 134 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Blue Ridge Health Care Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

Rehab & Nursing Center-Raleigh. In Section I.12, page 9, the applicant states that one of its *"affiliated entities"* operates Blue Ridge Health Care Center, which is located in Wake County. Blue Ridge Health Care Center is an existing nursing facility in Wake County with

134 nursing care beds. According to the Nursing Home Licensure and Certification Section, DHSR, within the 18 months immediately preceding the date of this decision, there were no incidents at Blue Ridge Health Care Center for which licensure penalties, suspension of admissions, provisional licensure, or certification deficiencies constituting substandard quality of care were imposed on the facility. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

C
All Applicants

The proposals submitted by all the applicants are consistent with all applicable Criteria and Standards for Nursing Facility Services, promulgated in 10A NCAC 14C .1100. See discussion below.

.1101 INFORMATION REQUIRED OF APPLICANT

.1101(a) The rule states *"An applicant proposing to establish new nursing facility or adult care home beds shall project an occupancy level for the entire facility for each of the first eight calendar quarters following the completion of the proposed project. All assumptions, including the specific methodologies by which occupancies are projected, shall be stated."*

-C- **Hillcrest-Wake Forest**. In Section II.1, page 16, the applicant projects occupancy levels for the first eight quarters for the proposed facility and in Section IV.2, pages 79-91, and Exhibit 14, the applicant provides the assumptions used to project occupancy.

-C- **Wake Health & Rehab-Cary.** In Section IV.2, page 95, the applicants project occupancy levels for the first eight quarters for the proposed facility and in Section IV.2(e), page 96, provide the assumptions used to project occupancy.

-C- **Britthaven-Brier Creek.** In Section IV.2, pages 145-146, the applicants project occupancy levels for the first eight quarters for

Attachment 5:

Copies of Articles Referenced in Written Comments

Citizen Times

NEWS

HCA, Mission hit with 2nd WNC antitrust suit in a year, this one from a Transylvania city

Andrew Jones
Asheville Citizen Times

Published 4:22 p.m. ET June 6, 2022 | Updated 6:05 p.m. ET June 6, 2022

ASHEVILLE - Nashville-based HCA Healthcare is facing its second antitrust lawsuit out of Western North Carolina in less than a year after the city of Brevard filed in district court June 3, claiming the company holds "monopoly power" in some health care service markets and that the "future of health care competition in Western North Carolina ... is at risk."

Brevard's lawsuit follows closely on the heels of an antitrust lawsuit filed by several community members in August 2021, making it the second in a year filed against the for-profit health care behemoth, the largest hospital system in the nation.

It proposes class action for "unlawful restraint of trade and monopolization" and seeks damages and relief through a jury trial.

The history of WNC's antitrust action against HCA Healthcare:

- HCA/Mission hit with anti-trust lawsuit, accused of exorbitant prices, declining quality
- HCA anti-trust lawsuit filed in Asheville gets extension, new deadlines
- HCA: Asheville residents' anti-trust lawsuit is an 'end-run' around Mission hospital sale
- AG Stein says he 'will not hesitate to act' if abuses in lawsuit against Mission are true
- NC Treasurer files interest in HCA anti-trust suit; plaintiffs reiterate concerns
- AG Stein hears WNC leaders on Mission sale fallout, says he's eyeing merger law changes
- Mission nurse on HCA fallout during merger hearing: Shocked and horrified

The for-profit HCA Healthcare purchased the Mission Hospital system in 2019, and the lawsuit says it now holds a monopoly market share — 70% or more — in seven

counties: Yancey (90.9%), Madison (90%), Buncombe (86.6%), Mitchell (85.4%), Transylvania (78.7%), McDowell (76.4%) and Macon (74.7%).

Transylvania Regional Hospital is in Brevard, the county's seat, and is one of five hospitals in WNC owned by HCA Healthcare and in Mission Health regional system.

“Our lawsuit is being brought at a time when providing affordable health care insurance plans for working families and governmental employees, such as firefighters, police, and teachers, and controlling health care costs have been top priorities for the city of Brevard and members of the class, and the business communities they serve,” Brevard Mayor Maureen Copelof said in a news release disseminated the same day the lawsuit was filed.

She said over the past few years, the community has "repeatedly expressed concerns" about what they say are declining health services, difficulty in obtaining those services and high costs.

"Our attempts to address these concerns directly with HCA have been rebuffed,” Copelof said.

HCA and Mission Health spokesperson Nancy Lindell said in a statement that the lawsuit was "beyond disappointing."

She said Copelof recently had requested a meeting with HCA CEO Sam Hazen.

Lindell called that meeting, which included other community leaders, positive and productive.

"We hoped that meeting would be the beginning of a thoughtful and ongoing dialog about healthcare in the city of Brevard and the broader Transylvania County region," Lindell said. "In fact, we provided information requested during the meeting and hosted our first community council meeting just this week."

Lindell noted Copelof in the release did not mention this "apparently long-planned lawsuit, which is frustrating and undermines what we thought were sincere efforts to build open, constructive relationships and lines of communication."

She said the company will now turn its attention to "vigorously defending" the lawsuit.

HCA is already doing that in another case currently waiting judgment in Raleigh's North Carolina Business Court.

There, the antitrust suit brought in August and aimed at HCA's Mission Health flagship operation in Asheville is waiting a decision on whether it can move forward in Buncombe Superior Court.

That case has garnered support from N.C. Attorney General Josh Stein and state treasurer Dale Folwell: both filed amicus briefs in the case, supporting the plaintiffs, Folwell in his capacity as an individual, not as an elected official.

Complaints to the AG: AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story

Demand for safer work conditions: Mission health care workers demand safer working conditions, join national nurses action

Brevard's lawsuit overlaps in many aspects with the Buncombe lawsuit, both noting variety of care options — notable general acute care hospital services — has dwindled since the 2019 purchase and prices have become problematic for the average patient.

The Brevard case, according to the release, is on how the company through monopoly power, is hurting citizens.

"The lawsuit alleges that HCA engaged in a series of predatory tactics designed to impede competition between health care providers," the release stated. "As a result, Brevard, its citizens, and others throughout western North Carolina have paid inflated prices for lower-quality health care."

HCA actions, it went on to state, have also harmed Brevard and its community by:

- Making changes to charity care, impacting some of the most vulnerable members of the community.
- Performing and billing for unnecessary procedures.
- Causing the loss of experienced and highly qualified physicians and other health care providers from the HCA system.
- Reducing the availability of appointments for health care services.

Lindell countered, emphasizing the hospitals' recent successes, specifically those at Transylvania Regional.

"We are proud of our commitment to western North Carolina and the significant investments we have made to serve Brevard and improve patient care," she said.

According to Lindell, those include:

- Missions Health's provision of more than $277 million in charity care and uninsured discounts in 2021.
- More than $14 million in significant infrastructure projects at Transylvania Regional Hospital, renovating three operating rooms, replacing both the MRI and CT and adding a new helipad.
- Provision of access to new specialties there, with five recently added primary care providers in the area and renovated the primary care practices.
- Transylvania Regional's recognition by Healthgrades for Pulmonary Care Excellence and its top 10% national ranking for overall pulmonary services.

"Health care is absolutely critical to the welfare of our community," Copelof told the Citizen Times by phone June 6. "To have good health care we have to have three things. It has to be affordable, it has to be accessible and it has to be of high quality. That's what I'm looking for. That's what I'm trying to ensure that our community has."

Andrew Jones is Buncombe County government and health care reporter for the Asheville Citizen Times, part of the USA TODAY Network. Reach him at @arjonesreports on Facebook and Twitter, 828-226-6203 or arjones@citizentimes.com. Please help support this type of journalism with a subscription to the Citizen Times.

ADVERTISEMENT

Nurses rally outside Mission to again push for safe staffing on Nationa

by Stephanie Santostasi
Thu, January 26th 2023 at 12:27 PM

JAN. 26, 2023 - Nurses rallied outside Mission Hospital Thursday morning, Jan. 26, along with thousands of other nurses across the nation doin, Action, spearheaded by the organization National Nurses United. The aim in Asheville was to, again, call for safe staffing levels, as the nurses rc to be understaffed is putting both patients and staff in danger. (Photo credit: WLOS staff)

TOPICS: ASHEVILLE ASHEVILLE,NORTH CAROLINA,UNITED STATES HEALTH MEDICAL PHARMA MISSION HEALTH LESTER

for a National Day of Action.

That included some nurses at Mission Hospital in Asheville. They continue to push for safe sta

This rally at Mission is the first one since the hospital made national headlines earlier this mo

Nurses News 13 spoke with Thursday said, despite that national attention, nothing has chang

MISSION HOSPITAL NURSES RALLY TO HIGHLIGHT CONCERNS ABOUT WORKPLACE VIOLI

NEWS
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GAME CENTER
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Nurses rally outside Mission to again push for safe staffing on National Day of Action

“The whole country saw firsthand just what hospital management thinks of us on the Nightly
said Shelby Runkles, a cardiovascular ICU RN at Mission. “The fact that management has no d
documentation of the staffing crisis at our facility is exactly why we need to take action like th
paperwork, we’ll make sure they see us outside.”

“We continue to be ignored by management,” said Kerri Wilson, a registered nurse at Mission

Wilson and others said they want to end their profession’s staffing crisis by making HCA provi
to care for patients.

MISSION HOSPITAL NURSES RALLY FOR PATIENT SAFETY; CITE CONCERNS OF CHRONIC S

She said it continues to be an issue — especially in the emergency department.

“The problem is, there’s no nurses upstairs in the other parts of the hospital, so it just causes
"Everyday, we’re having beds that aren’t being utilized for patients, and so, that means that p
and so there are days where there’s well over 100 patients just waiting,” Wilson added.

MISSION HEALTH NURSES JOIN IN NATIONWIDE ACTION AGAINST REPORTED UNSAFE W

A Mission spokesperson responded to those claims made by the nurses in the following state
Thursday morning:

*"While the NNU has chosen to attack hospitals across the country, our focus is on providing the be
patients. This labor union has a history of this type of activity, which includes using misleading info*

are doing everything possible to hire more nurses and other clinical support roles.

We are proud of the high-quality care we provide and continue to recruit new nurses with 19 recru the next few months. Our $20 million wage increase in September 2022 has resulted in more than the Mission Health team. We have received many recent recognitions for our quality and safety fro healthcare organizations including our recent Leapfrog Grade A and HealthGrades America's 50 B

We value all members of our care teams and neither this, nor any other labor union activity, will c commitment to quality, safe patient care and services to our patients and this community."

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What we know about nursing home worker, 20, killed after opening fire at Trump rally

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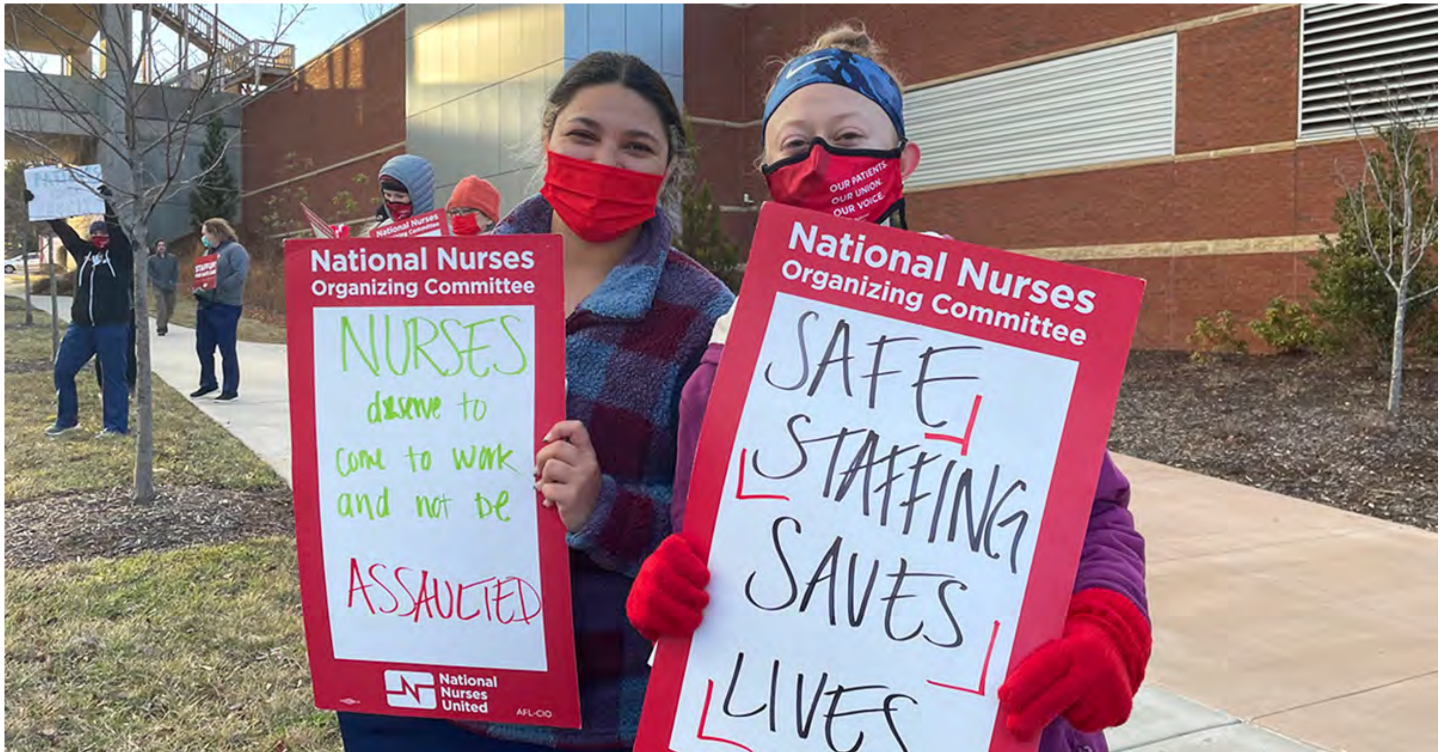
National Nurses United

(/)

PRESS RELEASE

Mission Hospital nurses to hold a rally over HCA's failure to protect patients and nurses from assaults and other unsafe working conditions

National Nurses Organizing Committee/National Nurses United April 07, 2023



RNs to protest unsafe staffing, workplace violence, and broken equipment

Registered nurses at Mission Hospital, in Asheville, N.C., will hold a rally on Monday, April 10, to highlight their patient safety concerns, including increased incidents of workplace violence, broken hospital equipment, and unsafe staffing levels, announced National Nurses Organizing Committee/National Nurses United (NNOC/NNU) today.

"HCA is at it again with prioritizing profits over patient care," said Hannah Drummond, RN in the emergency department at Mission Hospital. "As an emergency room nurse, it is unacceptable to have patients waiting more than 12 hours to receive care. Instead of increasing staffing in the Emergency Department to reduce wait times, HCA cut staff and sent nurses home. This is unconscionable. HCA doesn't value our patients and the community we serve."

Whenever nurses have an unsafe staffing assignment that may lead to negative patient outcomes, the RNs document it in an Assignment Despite Objection (ADO) form and submit it to hospital management. In a recent ADO, a nurse reported that more than 25 patients had to wait in the waiting room for an entire day before being seen by a nurse.

Who: RNs at Mission Hospital
What: Rally for patient safety and safe staffing
When: Monday, April 10, 8:00 a.m.
Where: Mission Hospital, 509 Biltmore Ave, Asheville, NC, 28801, on the corner of Hospital Dr. and Biltmore Ave.

"During my tenure as a cardiovascular intensive care unit (CVICU) nurse at Mission Hospital, I have seen the quality of care diminish so rapidly," said Katlin Myers, CVICU RN. "The cardiovascular ICU has some of the most vulnerable patients, yet we are consistently given more patients than nurses can safely handle. HCA must put our patients first."

In another recent ADO submitted to the hospital, a cardiovascular nurse documented an unsafe staffing assignment that resulted in a patient soiling themselves in bed. With appropriate staffing levels, patients would not be waiting so long for nurses to assist them to the restroom, preventing such incidents from occurring.

Unsafe staffing is also affecting nurses who work at Copestone, the acute inpatient psychiatric care units owned by HCA. Nurses on the night shift face frequent incidents of workplace violence, including physical attacks.

“Our patients in behavioral health deserve the highest quality of care HCA can provide, but when we are working short staffed, it makes the units dangerous for all health care workers,” said Susan Pitcher, RN in the Copestone adolescent unit. “Meds are delayed, meals are delayed, and care is delayed. HCA should reprioritize its record profits and put its resources into protecting our patients and staff.”

Copestone nurses documented numerous unsafe staffing assignments that resulted in delayed safety rounds and missed care — patients who did not receive the additional assessments they needed. Nurses say management’s response was that nurses should “try things out as is” and “let the hospital know if the dangerous working conditions become unmanageable.”

In addition to unsafe staffing and workplace violence, nurses have contended with broken equipment for months. For example, the modules on some ICU beds that help manage critical patients are not working. Vein finder lights that assist nurses to find veins so they can easily insert an IV are either broken or missing. Despite nurses reporting these ongoing problems to the chief nursing officer, they have not been fixed. Repairs to the ICU beds have been extremely slow.

National Nurses Organizing Committee represents nearly 1,500 registered nurses at Mission Hospital.

National Nurses Organizing Committee is an affiliate of National Nurses United, the largest and fastest-growing union and professional association of registered nurses in the United States with nearly 225,000 members nationwide.

Continuing Education Classes

CE courses are free to National Nurses United members.

See all classes (https://www.nationalnursesunited.org/ce-classes)

WAKE FOREST
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Mission Hospital's Quality Ratings Following HCA's Acquisition

A Preliminary Report

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Wake Forest University
Health Law and Policy Program

February 9, 2024

WORKING DRAFT

This preliminary report is one part of a larger study, funded by the Arnold Foundation,[1] examining what lessons can be learned from the events leading up to and following HCA Healthcare's 2019 purchase of the Mission Health system based in Asheville, North Carolina (NC). Findings from this portion of the research are being released as a "working draft" in order to give interested parties and the public a preliminary look at the initial analyses. Comments directed to the author (Prof. Mark Hall)[2] are welcome. Following revision, a final full report will be issued later this year.

Acknowledgements: Colleagues at Wake Forest University who contributed to this work are Doug Easterling, Ph.D., Joe Singleton, J.D., and Laura McDuffee.

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[1] https://www.arnoldventures.org/
[2] https://school.wakehealth.edu/faculty/h/mark-a-hall
https://profiles.wakehealth.edu/display/Person/mhall

BACKGROUND AND SUMMARY

Prior to HCA's acquisition, Mission Hospital was regarded as one of the highest quality hospitals in the country. Following HCA's acquisition, however, numerous complaints have been made and serious concerns raised about diminishing quality of care – principally due to staffing reductions and turnover [discussed in a forthcoming section].[3] These documented complaints led to an extended state investigation that resulted in the federal government recently citing HCA Mission with nine instances of placing patients in "immediate jeopardy" – a rare and very serious charge.[4]

Curiously, however, HCA Mission has not seen a sharp decline in its overall ratings for quality of care from various reputable rating agencies such as *US News and World Report,* the Centers for Medicare and Medicaid Services, the Leapfrog Group, and Healthgrades.[5] Some measures have dipped, and others have remained steady, but only one measure has dropped substantially.

This report provides a detailed account of how and why Mission's quality rankings do not consistently track widespread perceptions that its quality has declined following HCA's acquisition. Hospital quality can be assessed in various ways. Some measures show good or high quality at Mission, while others show very poor quality. In summary:

- Measured by official surveys of patients' views, HCA Mission now rates near the very bottom, both in North Carolina and nationally.
- Mission's ratings are stronger under objective measures of safety and outcomes. Nevertheless, those measures are not at the same level of excellence Mission maintained prior to HCA's acquisition.
- There are some indications that hospital reporting practices and data limitations may have skewed some of HCA Mission's ratings upwards.
- Under HCA, Mission appears to address quality and safety issues somewhat selectively, rather than striving for excellence across the board. This selective focus is consistent with HCA's status as a for-profit organization with an obligation to maximize profits for investors, and is consistent with its market position that leaves dissatisfied patients and physicians with limited alternatives.

WORKING DRAFT

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[3] https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed
https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-ashevilles-hca-mission/8370318002/
https://www.citizen-times.com/story/news/local/2022/12/27/hca-mission-health-had-year-of-lawsuits-staff-patient-complaints/69754830007/
[4] https://avlwatchdog.org/conditions-at-ashevilles-mission-hospital-pose-immediate-jeopardy-to-patients-health-and-safety-state-investigators-report/
https://www.citizen-times.com/story/news/local/2024/02/05/federal-government-declares-immediate-jeopardy-at-mission-hospital/72478250007/
[5] https://missionhealth.org/awards/

METHODOLOGY

This report is based primarily on extensive analysis of quality metrics,[6] supplemented by interviews with "key informants." These interview sources are North Carolina professionals, mostly from Asheville and surrounding counties, and include clinicians and former managers at Mission who are well-placed to have insightful knowledge about the questions studied.[7] Documentary and interview information was analyzed using qualitative methods that are standard for this type of research.[8]

MISSION'S NATIONAL PROMINENCE PRIOR TO HCA

Prior to HCA's acquisition, Mission Hospital was regarded as one of the highest quality hospitals in the country. In 2004, the Economic and Social Research Institute chose Mission as one of just four "exemplary hospitals" across the country to study in depth, in order to inform other hospitals about the "best practices" that "contributed to the success" of "high-performing hospitals."[9] These researchers concluded that "Mission [was] an excellent example of how a variety of factors can come together to promote quality of care in a large institution, ... [because] the drive to do whatever it takes to provide the best possible care seems to permeate the organization, from the Board to the executive levels to the bedside." The researchers "heard consistently that both the CEO and chief medical officer at Mission [were] strong champions of quality—not just reacting and responding to problems but taking action to move the institution ahead and keep it strong."

Mission maintained this national and regional excellence over the ensuing decades, up to the point of HCA's acquisition. One indication of regional excellence is the ranking done by the *Business North Carolina* magazine. In each of the seven years prior to HCA's purchase, this respected publication rated Mission the best or second best hospital in the state.[10] Nationally, IBM Watson Health selected Mission and its affiliated hospitals as one of the top 15 hospital systems in the country -- in six of the seven years prior to HCA's acquisition.[11] Mission was the only hospital system in NC to make IBM Watson Health's top-15 list and the only system in the entire country to make this list so frequently.

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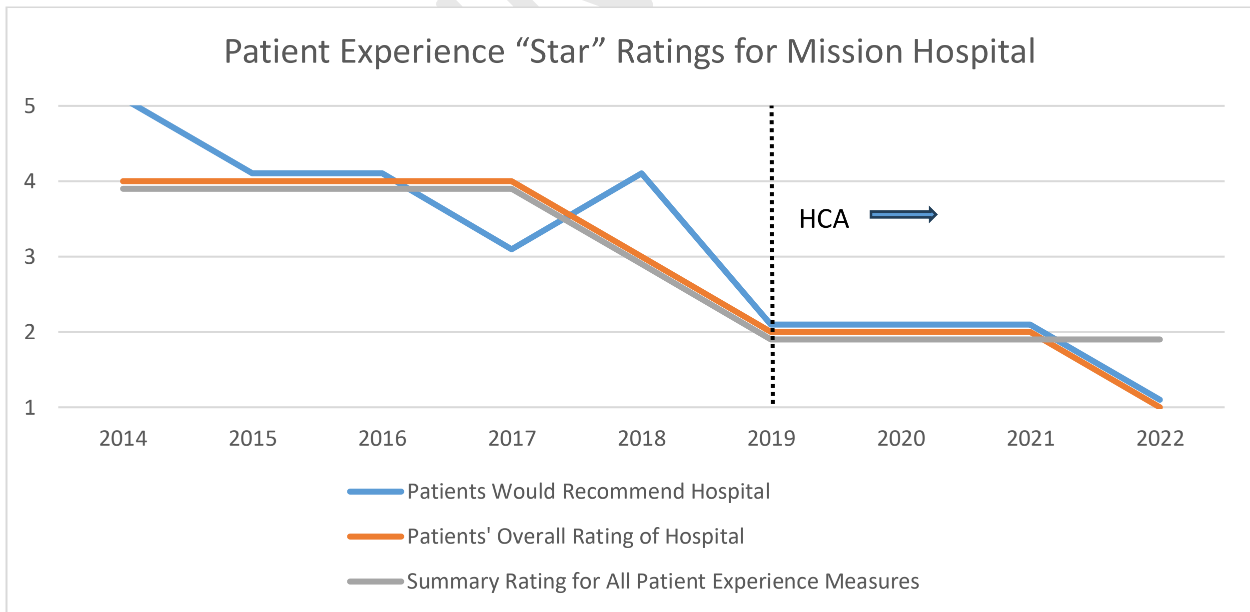
[6] For readability, this report cites publicly available information mainly just by website URL links.
[7] These interview sources were identified in a variety of ways, including their affiliations with key institutions and through respondent-driven referrals. To avoid any possible appearance of bias, no sources were identified through the nurse's union or its representatives.
[8] "Triangulation" is one such method, by which information from one type of source (interview, documentary, or data) is cross-checked with information from other types to determine whether either confirmation or inconsistency exists.
[9] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-overview-and-lessons
[10] https://businessnc.com/north-carolinas-2018-best-hospitals/. The magazine states that the rankings are based on "25 metrics ... [from] the U.S. Centers for Medicare & Medicaid Services, including patient-satisfaction surveys, infection rates, and readmission and death rates for common conditions and procedures. We also consider criteria from insurer Blue Cross and Blue Shield, U.S. News & World Report and The Leapfrog Group, a Washington, D.C.-based organization that grades hospitals based on patient-safety records."
[11] https://www.readkong.com/page/watson-health-15-top-health-systems-study-2018-3286465. Similar to other such rankings, this one is based on weighted composite measures of mortality, infections, complications, costs, and patient satisfaction. https://www.pinc-ai.com/100-top-hospitals

PATIENT EXPERIENCE RATINGS UNDER HCA

Following HCA's acquisition, Mission no longer receives these same accolades. While for the most part, Mission continues to receive positive ratings, there nevertheless has been a notable decline in several quality indicators.

Most strikingly, Mission's patient experience ratings have plummeted under HCA. This is seen, for instance, in *Business North Carolina's* rankings of hospitals statewide based on a systematic federal survey of the percentage of patients who would recommend the hospital to others. In the six years prior to HCA's acquisition, Mission Hospital's state rankings ranged from 3rd to 7th on this recommend-to-others indicator, but during the first year under HCA (2019), Mission's patient-experience ranking suddenly dropped to a statewide tie for 18th-23rd.[12] In more recent years, Mission's patient experience ratings have dropped it entirely out of the top 25 statewide.

This plummet is based on data collected and reported by the federal government, through the Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey, which it administers each year to several hundred randomly selected patients at each hospital.[13] One of the HCAHPS survey's key summary measures is simply whether the patient would recommend the hospital to others.[14] The percentage responding no vs. yes is converted to a scale from one star (worst) to five stars (best).[15] From 2014-2018, Mission Hospital averaged four stars. In 2019, however, the first year under HCA, this patient rating (along with others shown in the following Figure) dropped to two stars, and remained there, until 2022, when it dropped to one star.



[12] https://businessnc.com/?s=%22patient+picks%22&post_type=post
[13] https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey; https://hcahpsonline.org/en/
[14] Verifying the robust strength of this indicator, see https://onlinelibrary.wiley.com/doi/10.1002/hast.1523
[15] Each hospital's score is adjusted based on various characteristics of the patients who respond, so that the star rating reflects how a hospital does compared to hospitals with similar patients nationally. https://hcahpsonline.org/

A one-star rating places Mission Hospital in the bottom 3.6% percent of hospitals nationally on whether its patients would recommend the hospital to others. No other NC hospital with more than 300 beds was rated this low in 2022.[16]

Similar, but not as extensive, declines can be seen in the star ratings that patients or family members give Mission Hospital on the widely used Yelp and Google review internet platforms. In the six years prior to HCA's purchase, Mission averaged 3.0 stars on both Yelp (40 reviews) and Google (179 reviews). In the five years following HCA's purchase, Mission's average rating dropped to 1.7 stars on Yelp (98 reviews) and 2.2 on Google (521 reviews).[17]

OTHER QUALITY MEASURES

To obtain a more expansive view of hospital performance, rating agencies routinely measure the quality of care in ways other than just patients' experience. A variety of respected sources rate hospitals based in substantial part on objective measures of patient outcomes and hospital processes, such as mortality or infection rates, or taking steps to avoid complications. For several of these key ratings, Mission did not decline initially following HCA's acquisition. Unlike patient surveys, however, these objective measures have an inherent time lag due to the 2-3 years required to collect relevant data, analyze it, and publish it. Once most of the relevant data began to come from the post-acquisition time frame, Mission's ratings based on objective measures declined on several fronts, although not as steeply as for patient experience.

For instance, referring again to overall rankings from *Business North Carolina*, Mission continued to be listed as first in the state in 2019, based on safety and quality data from earlier years. But, by 2022, Mission's overall ranking had slipped to 12th in the state.[18]

Similarly, on a national level, the data analytics firm IBM Watson and its successor (Premier or PINC) have long ranked Mission among the country's top 15 health systems -- a distinction that Mission had held for six of the seven years prior to HCA's purchase, but not once following HCA's acquisition in 2019.[19] IBM Watson also had consistently ranked Mission Hospital among the top 50 cardiovascular hospitals nationally for at least the five years prior to HCA's acquisition. Under HCA, Mission maintained that distinction through 2021, but has not received it since then.[20] This delayed drop coincides with the 2-3 year time lag between the collection of core data and the announcement of these rankings.[21]

Similar delayed degradation in Mission's national rankings can be seen from other sources, which use similar but somewhat different methodologies. All such ranking methodologies have limitations, but some

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[16] The other four NC hospitals with one star that year were Central Carolina in Sanford, Wilson Medical Center, Maria Parham in Henderson, and Halifax Regional in Roanoke Rapids.

[17] This count was done in December 2023. The Yelp ratings are based on reviewers it "recommends" (using an algorithm that is sensitive to how reviewers behave elsewhere). Including also the "not recommended" Yelp reviews does not change the pre-HCA average, but doing so increases the post-HCA average to 2.0.

[18] https://indd.adobe.com/view/9a02585a-12c1-44a9-a8d9-eb6b1cd638c0

[19] Rankings are not provided below the top 15, but the firm reported most recently that Mission is not among the top one-fifth of health systems.
https://web.archive.org/web/20220707133345/https://www.ibm.com/downloads/cas/GDBBYRWE

[20] https://www.pinc-ai.com/100-top-hospitals/50-top-cardiovascular-hospitals/results/

[21] https://cdn.sanity.io/files/dcd4gsuh/production/85dff22267f5c0ca207ea486309d6bc67bd0283b.pdf. Also of note, this ranking is based in part on performance trends measured as much as 8 years prior to the ranking.

are stronger than others, and some are notably weaker.[22] Among the strongest is *U.S. News and World Report*. In the five years prior to HCA's acquisition, *US News* ranked Mission from 5th to 7th statewide for overall quality. The first two years under HCA, when most underlying data predated the acquisition, *U.S. News* continued to rank Mission in the top 10 statewide. But since 2021, Mission has fallen out of the top 10 in the state and it currently ranks in a 4-way tie for 12th-15th.[23] While this is a respectable ranking, it is a distinct step down from the very top ranks that Mission occupied prior to HCA.

The federal government maintains another widely referenced rating system, which awards hospitals from one (lowest) to five (highest) stars.[24] In the Spring of 2021, which is the first year relevant data fell primarily under HCA management, the federal government downgraded Mission Hospital from the top 5-star rating, which fewer than 10 percent of hospitals receive nationally, to 4 stars. Four stars is still respectable, but it puts Mission in roughly the top half of rated hospitals in North Carolina, rather than the very top tier.[25]

SOME RATINGS REMAIN HIGH

Two exceptions to declining quality ratings are the Leapfrog Group and Healthgrades, both of which continue to give Mission top ratings. Notably, neither of these rating firms includes in their overall ranking metrics any data on patient experiences or satisfaction. Also of note, both of these firms charge hospitals a fee in order to publicize their rankings.[26] Accordingly, these two rating firms use "grading curves" that tend to rank hospitals more highly than do other rating firms.[27] That does not necessarily mean their ratings are invalid; however, independent evaluators consider their methods to be less rigorous and reliable than the other ranking firms discussed so far.[28]

Healthgrades

Mission's most notable accolade is from Healthgrades, which continues to rank Mission among the country's top 50 hospitals. For the past several years, Mission has been the only such hospital in NC.[29] On

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[22]http://catalyst.nejm.org/evaluation-hospital-quality-rating-systems/
https://www.advisory.com/topics/clinical-quality/2019/11/metrics-used-in-hospital-quality-rating-programs
https://www.chicagobooth.edu/review/hospital-ratings-are-deeply-flawed-can-they-be-fixed
https://avlwatchdog.org/ratings-company-says-ashevilles-mission-is-the-best-hospital-in-north-carolina-we-seek-a-second-opinion
[23] https://health.usnews.com/best-hospitals/area/nc
[24] https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/
[25] https://www.medicare.gov/care-compare/results?searchType=Hospital&page=1&state=NC&sort=highestRated
[26] The Leapfrog rating is done by a nonprofit group formed primarily by employers. Healthgrades is owned by a private-equity-backed firm.
[27] For instance, in 2023 Healthgrades awarded 864 hospitals for either "excellence" in patient safety or being "outstanding" in patient experience. https://www.beckershospitalreview.com/rankings-and-ratings/healthgrades-recognizes-800-hospitals-for-patient-safety-experience.html. As discussed below, Leapfrog typically gives an A to about a third of hospitals, and over half receive at least a B. In contrast, the federal government's rating system awards 4 or 5 stars to fewer than a quarter of hospitals, with 5 stars going to less than 10 percent.
https://www.medicare.gov/care-compare/resources/hospital/overall-star-rating
[28] http://catalyst.nejm.org/evaluation-hospital-quality-rating-systems/
[29] https://www.healthgrades.com/quality/ratings-awards/reports/americas-best-hospitals

WORKING DRAFT

the face of it, this distinction is counter-intuitive,[30] and is inconsistent with the substantial body of data and analysis reviewed so far [and discussed in in a forthcoming section]. One explanation is the long eight-year "look-back" period that Healthgrades uses to classify and rank hospitals.[31] This expanded window means that Mission's current ranking is still based in significant part on how it performed for several years prior to HCA's acquisition.

Another explanation is that Healthgrades' top-50 list is not based on the full set of measures that compose other leading rankings. For instance, Healthgrades' top-50 rating does not include patient experience evaluations, which it lists separately. In that separate listing, Mission is not among the ten NC hospitals that receive Healthgrades' patient experience award,[32] and Healthgrades notes that Mission is significantly below national averages for patient experience.[33]

Another key feature of Healthgrades' best hospital ranking is that the majority of metrics focus on the performance of surgical procedures, and less so on medical care more generally.[34] Successful surgery depends to a great extent on the surgeon's skill, and so it appears likely that Mission has retained a skilled medical staff for surgical and other interventional procedures. These are also the kinds of hospital services that informed sources noted are more profitable and therefore for which HCA typically provides more support.[35]

Contrasting with Healthgrades' procedure-centric metrics are those that focus more on general medical care. Examples include pressure ulcers, catheter-related infections, hospital falls, and various aspects of post-operative care. For this group of preventable safety measures, Mission is one among 14 NC hospitals, and 445 hospitals nationally, in Healthgrades' award category for "patient safety indicators."[36] Similarly, Leapfrog's latest ratings, discussed below, rank Mission "better than average" for five of seven metrics relating to surgery, but it scores better than average for only about half of its other measures (and "worse than average" for almost a quarter of those other measures).[37]

In sum, Healthgrades' ratings indicate that, under HCA, Mission has maintained top performance selectively rather than across the board. Its ratings are exemplary for a range of surgical procedures, but not as outstanding for the broader array of hospital care delivered by nurses, hospitalists, and other clinical staff. As discussed in [a forthcoming section], these are also the areas where HCA has sought to

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[30] Adding a degree of incredulity is that, even when expanding the ranking to the country's top 250, only one other little-known NC hospital (Pardee) has been listed the last several years. https://www.healthgrades.com/quality/americas-best-hospitals/north-carolina?americasBestAwardType=top250

[31] https://www.healthgrades.com/quality/hospital/americas-best-hospitals-for-clinical-excellence-2024-methodology. In addition, data for each of those years reaches back several additional years, such that current rankings are based, at least in part, on data from a decade ago. https://www.advisory.com/content/dam/advisory/en/public/shared/Daily-Briefing/2022/HealthGrades_BestHospitals_2022.pdf

[32] https://www.healthgrades.com/quality/outstanding-patient-experience-award/north-carolina

[33] https://www.healthgrades.com/hospital-directory/north-carolina-nc/mission-hospital-hgstcb797b36340002#overview

[34] https://www.healthgrades.com/quality/healthgrades-americas-best-hospitals-for-clinical-excellence-methodology

[35] This point is discussed more in [a forthcoming section].

[36] https://www.healthgrades.com/quality/patient-safety-excellence-award/north-carolina

[37] https://www.hospitalsafetygrade.org/h/mission-hospital. However, a pattern of performing better on surgical than on general medical measures is not seen consistently in earlier years or from other ranking agencies.

economize and so where Mission has experienced greater staffing cutbacks and turnover.[38]

Leapfrog

The Leapfrog Group is another rating agency that continues to give Mission high marks. Leapfrog is a respected nonprofit rating agency formed by employers to evaluate hospitals they select for their health plan networks. Like Healthgrades, however, hospitals pay Leapfrog a fee to use its ratings for promotion purposes. Accordingly, Leapfrog is not known as an especially tough grader. Nationally it awards either an A or B to over half of hospitals, with roughly a third receiving A's.[39] North Carolina hospitals do especially well.[40] In the most recent ratings, almost half received A's.[41]

Leapfrog's ratings (which it issues twice a year) have two other notable features. First, as noted above, unlike several other rating agencies Leapfrog does not include patient-reported experience or (dis)satisfaction. Second, Leapfrog relies on both data that regulators routinely collect, and data that hospitals self-report through an annual survey. However, about half of hospitals do not respond to Leapfrog's voluntary survey; for those hospitals, Leapfrog either omits the self-reported measures, or it uses proxy substitutes discussed below.

Prior to HCA's acquisition, Mission usually received A's from Leapfrog, with only occasional B's.[42] In the first two and a half years under HCA, however, Mission averaged B's, and at one point (fall 2019) it dropped to a C. Since fall 2021, however, Leapfrog has awarded A grades to Mission.

As suggested above, there are three explanations for Leapfrog reporting good performance despite other worrisome indicators. First, due to somewhat lenient grading, an A places Mission merely in the top half of the North Carolina hospitals that Leapfrog evaluates. Second, Leapfrog does not include data that reflect patients' views or experiences, which have dropped substantially (as discussed above). Third, Leapfrog, more than other rating agencies, allows hospitals to make strategic decisions to avoid reporting certain data elements that might be unfavorable.[43]

DATA INTEGRITY

To illustrate the point just mentioned, until recently Mission consistently responded to Leapfrog's annual self-reporting survey, but Mission did not do so in 2023. Two of the data elements in that survey relate to

[38] https://www.hospitalsafetygrade.org/h/mission-hospital

[39] https://www.hospitalsafetygrade.org/media/file/ExplanationofSafetyGrades_Fall2022.pdf
https://www.advisory.com/content/dam/advisory/en/public/shared/Daily-Briefing/2020/Cheat-Sheet--Leapfrog-Safety-Grades_Fall2020.pdf

[40] https://www.wral.com/story/north-carolina-ranks-no-1-in-us-for-hospital-safety/20274858/
https://www.northcarolinahealthnews.org/2017/11/03/hospital-safety-ratings-2017/

[41] https://www.hospitalsafetygrade.org/search

[42] https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf
https://wlos.com/news/local/leapfrog-group-wnc-hospitals-graded-among-the-best-worst-in-the-state
https://www.healthcarefinancenews.com/news/full-list-these-844-hospitals-earned-fall-2016-leapfrog-ratings

[43] https://www.hospitalsafetygrade.org/HospitalFAQ. Hospitals can purchase a "calculator" that helps them anticipate whether submitting or not submitting self-reported data will be to their advantage.
https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0629
https://premierinc.com/newsroom/blog/hospital-rankings-how-to-stay-on-top-with-pinc-ai-quality-enterprise

hospital-acquired infections. Pre-2019 records are not available, but since 2019, Mission has consistently scored below average on two of those measures (C. diff infection and infection following colon surgery). In 2023, however, when Mission declined to provide these data items (along with others that are more favorable to Mission), Leapfrog had to resort to its fallback "imputation" method that assigns Mission an average (rather than actual) score for these measures, based on the performance of similar hospitals.[44]

Other hospitals also make such decisions about how to put their best face forward. However, several informed sources pointed out that HCA has perhaps the best data analytic skills and methods in the industry,[45] and so it is especially adept at making these kinds of strategic decisions. One Mission doctor noted that, "when HCA came in, there were so many emails on metrics."[46] A former Mission administrator riffed that, with all the data HCA has, they "can manage things down to a gnat's butt."

Data analytics are key to helping hospitals address safety and improve quality by spotting problem areas or performance gaps, and HCA undoubtedly has used their prowess in that fashion, to improve quality performance. However, several sources also thought HCA does so selectively, by focusing on quality mainly in ways that do not cost a great deal to make measurable improvements. One former Mission administrator had the derisive view that HCA "won't spend a dime more than they need" to improve quality, as long as Mission stays at "a level that keeps them from getting into trouble." A local physician agreed that HCA is skilled at "being just good enough to stay out of trouble," but will not "spend what it takes go from the 90th to the 95th percentile" in quality, especially when doing so doesn't bring them any more business.

Finally, it merits mention that, when hospitals report data, either to Leapfrog or to other rating agencies, there is at least some potential for skewed or inaccurate reporting. This point is not at all unique to HCA Mission, but several examples can be noted from Mission's data. For instance, Leapfrog's annual survey asks hospitals to self-report on a number of measures relating to leadership, teamwork, and staffing. In 2019, when Mission's Leapfrog grade dropped to a C, it reported a nurse staffing measure that was below average. The following years, however, when its Leapfrog grade improved, Mission received a perfect score of 100 on this self-reported nurse-staffing measure.

A perfect score may have been technically accurate because Leapfrog's nurse-staffing measure was based primarily on the hospital adopting a recommended list of administrative plans and processes,[47] rather than on actual staffing levels. As discussed [in a forthcoming section], Mission's actual staffing levels are (to say the least) far from perfect. Thus, this scoring improvement does not reflect enhancements in actual nurse staffing. Based on that critical data limitation, Leapfrog began in 2023 to ask hospitals to report actual nursing hours per patient day.[48] Whether related or merely coincidental, 2023 is also the first year that Mission declined to respond to Leapfrog's survey.

In short, lifting the hood on how key metrics are assessed reveals a variety of ways[49] that hospitals can

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[44] Explaining this imputation method, see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517312/

[45] https://www.pressreader.com/usa/modern-healthcare/20181008/281762745204037

[46] Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog, March 23, 2022, https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/

[47] www.leapfroggroup.org/sites/default/files/Files/2014LeapfrogReport_NursingWorkforceBestPractices_Final.pdf

[48] https://ratings.leapfroggroup.org/sites/default/files/inline-files/2023%20Nursing%20Workforce%20Factsheet.pdf

[49] Yet another possible example is the practice reported at some other HCA hospitals of encouraging patients with

optimize their Leapfrog ratings. Other hospitals engage in similar practices,[50] but as noted above, several observers thought that HCA is particularly astute about maximizing available advantages.

Another example of a possible anomaly comes from data collected by the federal government relating to "timely and effective care,"[51] a measure that various rating agencies use. One of these data points is the percent of patients who leave the emergency room without being seen. Implausibly, Mission reports zero percent.[52] Statewide, the average is four percent, and only two other NC hospitals report zero percent, both of which are part of the HCA Mission system.[53] Prior to HCA's acquisition, Mission typically reported at or close to the statewide average of four percent.[54] Under HCA, however, in 2019 the reported percent of patients leaving Mission's emergency room without being seen suddenly dropped to, and largely remained at, zero.[55]

This abrupt improvement does not align with widespread reports [discussed in a forthcoming section] of chronic overcrowding and hugely extended wait times in Mission's emergency room under HCA's management.[56] One possible explanation emerges from interviews with those who currently or previously worked in Mission's ER, explaining how HCA Mission may be classifying being "seen" in a manner that "games the numbers." As discussed [in a forthcoming section], HCA has instituted a screening and triage process that entails doing abbreviated medical exams in the ER waiting room or triage area, but then leaving patients to wait many hours before receiving fuller evaluation and proper treatment. If HCA Mission were to record a cursory triage or screening assessment as being "seen," then this measure would show favorable performance even if a patient were to leave without a proper examination.

Thus, there is a plausible hypothesis that, more than actual substantive enhancements, HCA's management and reporting practices in classifying components of ER patient care explain the sudden,

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little prospect for survival to enroll in hospice, even though doing so does not necessarily alter the care they receive. According to these reports, a motivation for encouraging hospice is that, when under hospice care, a patient's death is not counted against the hospital in its mortality statistics.
https://doctorow.medium.com/americas-largest-hospital-chain-has-an-algorithmic-death-panel-5d6df28e2648
https://hcacarecrisis.org/hospice-transfers/
https://avlwatchdog.org/wrongful-death-suit-filed-against-hca-mission-alleges-catastrophic-medical-error-other-missteps/. One possible indication of this happening at HCA Mission comes from allegations in a malpractice case against Mission filed in 2024. https://www.nbcnews.com/health/health-care/doctors-say-hca-hospitals-push-patients-hospice-care-rcna81599. See also the Appendix to [a forthcoming section on ER care].

[50] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517312/

[51] https://data.cms.gov/provider-data/dataset/yv7e-xc69

[52] https://www.medicare.gov/care-compare/details/hospital/340002?city=Asheville&state=NC&measure=hospital-timely-and-effective-care. Since measures are reported in whole numbers, this likely signifies less than 0.5.

[53] The other three Mission hospitals report 1 percent.

[54] https://data.cms.gov/provider-data/archived-data/hospitals

[55] In 2021 Mission reported one percent.

[56] https://www.beckershospitalreview.com/legal-regulatory-issues/north-carolina-ag-sues-hca.html
https://mountainx.com/news/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/
https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/
https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/

sharp, and unique improvement in this one quality performance measure. Similarly, other management practices could affect how well other data components reflect true quality. Whether this hypothesis is accurate, and the extent to which it accounts for Mission's continuing high performance on various quality measures, is unknown. It is known, however, that, as a general matter, HCA excels at data analysis and process management.

QUALITY RATINGS IN PERSPECTIVE

Even crediting Mission with the full benefit of its favorable ratings under HCA, it is clear that Mission is no longer at the level of excellence it had achieved prior to HCA. Patients' ratings of their hospital experience have plummeted to the lowest level, and Mission no longer regularly scores at the highest levels under the more rigorous and widely respected systems that rate overall quality. Some objective measures of quality and patient safety are still high, however, and others are still respectable.

Despite maintaining respectable ratings, several area physicians noted cause for concern. They said that staffing cutbacks and turnover [discussed in a forthcoming section] have made medical mishaps more likely. Even though, in their experience, serious adverse events have mostly been avoided, these sources report that safety incidents are much more common than before -- happening "every single time we admit a patient" according to one doctor and "probably one every shift" according to another. This has amounted in one physician's view to a "flood of near misses" where bad outcomes are avoided only by knowing there is now a need to exercise much greater vigilance to double check aspects of care that previously were not an issue. As another physician described things, under HCA it feels "like juggling eggs, with more being thrown at you all the time, and having to catch them just before they hit the floor. So far [we] have been able to do that, but at some point . . . "

On the whole, the decline in quality under HCA left several observers with a feeling of resignation that, over time, "things will probably stabilize and we'll be left with a perfectly mediocre hospital," but never one that is again "great" or "nationally ranked." Several stressed that, despite plummeting patient ratings and diminished quality metrics, HCA has no real incentive to do better than average, acceptable, or enough to "stay out of trouble," considering that doing better "does not matter" if patients and physicians "have nowhere else to go." Many informed sources thought that this overall culture of passable quality is in sharp contrast with how Mission previously had been characterized, when national experts said that, at Mission, "the drive to do whatever it takes to provide the best possible care seems to permeate the organization, from the Board to the executive levels to the bedside—… not just reacting and responding to problems but taking action to move the institution ahead and keep it strong."[57]

[57] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-case-study-mission

HOSPITALS

Doctors' lawsuit: HCA Healthcare and TeamHealth overcharged patients

Recently unsealed case describes what they say is widespread use of unnecessary trauma alerts and added tests.

by **Asheville Watchdog**
June 19, 2023

The main emergency room entrance at Mission Hospital in Asheville. Credit: Asheville Watchdog photo by Starr Sariego

By Barbara Durr and Andrew R. Jones

Asheville Watchdog

Two long-time emergency room doctors have blown the whistle on what they say is fraudulent overcharging by HCA Healthcare, which owns Mission Health, and its medical staffing company, TeamHealth, according to a **recently unsealed lawsuit** filed last year.

HCA Healthcare and TeamHealth have intentionally run up patient costs with medically unnecessary trauma alerts and added tests, such as CT scans, extra blood samples and X-rays, according to the complaint from Allen Lalor and Scott Ramming. Both have served for more than two decades as emergency physicians in Mission Hospital in Asheville and its regional affiliates.

HCA Healthcare and TeamHealth have systematically defrauded the state and federal Medicare and Medicaid programs under the **False Claims Act**, according to the lawsuit.

The complaint notes that both companies, which are for-profit corporations, have been sued previously for over billing under the False Claims Act.

The lawsuit was one of two filed last year out of Western North Carolina alleging TeamHealth uses deceptive methods to charge patients for more care than they receive.

Another complaint filed in U.S. district court in Tennessee in November on behalf of Buncombe County alleged TeamHealth was coding ER patients for more severe medical situations than they actually experienced. The same attorneys representing the Mission emergency doctors also are representing Buncombe County, which is suing on behalf of nearly 3,700 employees and the health plan it established for them.

That case is ongoing in Knoxville, where TeamHealth is headquartered.

The emergency doctors' lawsuit was filed in June 2022 and was sealed until April 6 when the **US government declined** to intervene. With that decision by the US District Court for the Western District of North Carolina, the case had 90 days to proceed. If no action is taken by July 5, the case will be dismissed.

"We believe that these allegations are meritless and are pleased that the federal government chose not to participate in this case," Mission Health spokeswoman Nancy Lindell said.

TeamHealth spokesperson Josh Hopson declined to comment.

“We can only comment on information that is available on the public record,” DOJ spokeswoman Lia Bantavani said, “And there is nothing publicly available I can share on this matter beyond what is contained in the document you already have.”

Attorneys for Wallace & Graham, the Salisbury-based law firm representing the doctors, would not comment.

Trauma alerts are a lucrative source of profits for HCA, which can charge thousands of more dollars if one is activated. Doing so upon a patient’s arrival in the emergency room launches a variety of medical specialists’ care. The patient then incurs a trauma fee on top of any charges for treatment, procedures and medications.

Mission is the only certified Level II Trauma Center in Western North Carolina. It accepts all trauma patients in the region, making its emergency room one of the nation’s busiest.

A 2014 investigation by the ***Tampa Bay Times*** using 66,000 Florida trauma patients’ billing records found that HCA’s overcharging for trauma codes was on average $40,000 more than other state trauma centers for injured patients. When it came to severity of injury, HCA patients were, on average, the same as the state as a whole, according to the *Tampa Bay Times* report.

Doctors allege non-physicians activate codes

In the North Carolina whistleblower complaint, the doctors said unnecessary trauma codes were typically activated by a non-physician, often a physician’s assistant, who was given little time to make an actual assessment.

Ramming described a meeting in the office of Chad Patrick, the CEO of Mission Hospital, in which HCA Mission announced that it would lower the threshold for activating trauma codes and alerts, according to the lawsuit.

Lalor, who provided extensive internal memos from TeamHealth, said that a trauma alert would be activated if a geriatric patient on blood thinner (including aspirin) fell from any height with any sign of head trauma. Lalor considered this instruction too broad.

Trauma alerts were mandated for anyone older than 65 with a systolic blood pressure of 110 or less. Again, the doctors considered this to be far too crude a measure and overly inclusive, according to the complaint.

MORE HOSPITAL ISSUES IN NORTH CAROLINA

Expert: Rural hospitals are particularly vulnerable to increasing cyberattacks targeting health care facilities

by Daily Yonder July 5, 2024

In one instance, Ramming described an incident in which an 82-year-old patient, who had other medical problems, arrived by ambulance with a scrape on his head, and a trauma alert was needlessly activated.

“This is one of innumerable instances where geriatric patients are given unnecessary trauma designations for absurdly minor injuries, when a more rational approach would be to medically evaluate the patient and determine what the problem is, rather than mobilizing unnecessary resources,” Ramming said. “As is so often the case, in instances like this, this patient was actually medically sick and had no traumatic injuries.”

He noted that this patient’s visit to the emergency room occurred on a day when over 40 other patients were waiting to be seen, some for more than five hours. Ramming said these kinds of trauma alerts force other much more ill patients to wait.

In another unwarranted trauma alert, a 79-year-old patient arrived after a car accident, but had no injuries, according to the complaint.

Mission Hospital's emergency room is one of the busiest in the nation. Credit: Asheville Watchdog photo by Peter Lewis

Allegations of a surge in trauma activations

After April 15, 2020, when TeamHealth started delivering contracted services to Mission Hospital's Emergency Department, the number of trauma activations surged, according to the lawsuit. The doctors said the higher and more lucrative volume of alerts by TeamHealth and HCA Health occurred despite no change in the acuity of the patient population.

On one busy ER shift in May 2022, Ramming witnessed many medically ill patients getting trauma designations, yet many ending up going home, according to the complaint. When he commented on this to the physician's assistant who was on duty, the response was "trauma overcalls aren't a problem for corporate medicine," according to the complaint.

A similar alert that HCA Healthcare and TeamHealth frequently activate is a "sepsis alert," which triggers many tests and costly treatments. Sepsis is the body's extreme response to an infection and is life threatening.

Ramming described a case of an 85-year-old woman who came to Mission's Highlands hospital emergency room with cat scratches and was given a sepsis alert. He canceled the tests, which were "not needed for cat scratches, needless to say," he said.

Mid-level practitioners in the emergency department were incentivized to order numerous unneeded or redundant lab tests, including blood samples, urinalysis, laboratory analyses, metabolic panels, CT scans and X-rays, according to the lawsuit.

Multiple examples of redundant testing and scanning were in the doctors' medical records as part of the complaint. In one instance when a patient arrived in Mission's emergency room a few hours after undergoing urine tests at an urgent care facility, the hospital ordered repeat tests and the full array of sepsis tests. "There was no need for these repeat tests, and the patient was not ill enough to get the sepsis bundle," Ramming said.

He also noted that it was common to over-code patients as sepsis cases because it not only pads the bill for extra testing, but also pools non-septic patients with truly sick ones, lowering the overall mortality rate.

A blatant example of "how extreme HCA Mission has become in over-ordering tests," according to the complaint, occurred when a patient who had the jitters after consuming energy drinks was given Lab tests, oxygen, a chest X-ray and an IV.

"Even a layperson with common sense could explain this patient's jitteriness," Ramming said.

Unnecessary testing is ordered by physician assistants who perform triage for the emergency room, where they "have only a very limited ability to interview the patient, really examine the patient or spend time with the patient to determine what is really wrong with the patient," Ramming said.

The changes in practices by HCA and TeamHealth are presumably occurring at other large HCA and/or TeamHealth emergency departments, the complaint said. HCA, based in Nashville, is the largest hospital operating company in the US, with more than 180 hospitals.

The doctors also describe a performance metric system put in place by HCA Health that pressures doctors and other non-physician practitioners to see patients more quickly. A chief metric "is generally speed of service," according to the complaint.

"A conveyor-belt, fast food approach"

The changes imposed by HCA and TeamHealth "have forced physicians, mid-levels and nurses alike into adopting a conveyor-belt, fast-food approach to emergency medicine, which is counterproductive both for their experience as employees, and for the experience of patients."

The system is also used to rank doctors against one another and set compensation bonuses, according to the lawsuit.

Ramming has served as the assistant director of the Asheville Emergency Department. But after HCA and TeamHealth took over and he provided management with an honest report about the problems and poor practices there, he was demoted, according to the complaint. He continues to work at Mission Health. Lalor has retired. Neither doctor would speak with *Asheville Watchdog.*

Other doctors have called Mission's environment toxic for medical professionals, and **many have left** since HCA took over, *The Watchdog* has previously reported.

The North Carolina complaint is seeking three times the fraudulent charges to Medicare and Medicaid, civil fines and attorney fees.

Wallace & Graham also are attorneys for two antitrust class-action suits filed against Mission and HCA. One was brought last year by two counties and cities including Buncombe and Madison counties, and the cities of Asheville and Brevard, all of which have self-funded insurance plans. The other was brought by individual Asheville-area plaintiffs, the first WNC class-action lawsuit since the 2019 takeover. That case is still being litigated in North Carolina Business Court in Raleigh.

Attorney General Josh Stein is not getting involved with this case, according to spokeswoman Nazneen Ahmed. "Our office has declined to intervene at this time, but we are following it closely as we continue our work to ensure fair competition in health care in western North Carolina," Ahmed said.

In 2003, HCA was involved in the **largest health care fraud case in U.S. history** at the time, which resulted in $631 million in civil penalties and damages from false claims submitted to Medicare and other federal health programs.

PRELIMINARY EXPERT DISCLOSURE
MITCHELL LOUIS JUDGE LI, M.D.

June 21, 2022

1. Introduction.

The Corporate Practice Of Medicine ("CPOM") is an area where there is active litigation involving competing business models for emergency department ("ED") medical practice. *See, e.g., American Academy of Emergency Medicine Physician Group, Inc. v. Envision Healthcare Corp.*, No. 3:22-cv-00421-CRB, 2022 U.S. Dist. LEXIS 102766 (N.D. Cal. May 27, 2022) (order denying Envision's motion to dismiss – plaintiff's claim was that Envision business model violates CPOM rules in California). There is current controversy in the ED medicine sector, and there are new developments in the law, due to the upsurgence of private-equity-backed for-profit hospital and medical staffing companies. A range of practicing physicians, scholars and commentators, and nonprofit groups and associations, have noted controversial characteristics of CPOM and have commented on its legality or lack thereof.

It is important to note that CPOM is not ubiquitous nor are all hospital systems and healthcare companies CPOM violators. Numerous medical practices and hospitals follow non-profit models or other business models that do not violate CPOM rules. However, HCA Healthcare ("HCA") and Team Health Holdings ("Team Health" or "TH") are both aggressive in their CPOM model including by taking litigation risks as reflected by both companies' checkered litigation histories.

In this case, CPOM is relevant because there is a nexus between CPOM violations and overbilling of Medicare/Medicaid. Accordingly, input from one or more witnesses with special expertise in the relevant area of CPOM and Emergency Medicine, and/or related areas, is appropriate. Dr. Li is one such expert.

2. Professional Background.

Mitchell Louis Judge Li, MD, FAAEM resides in Black Mountain, NC. He grew up in Marlborough, MA where he earned the "First Aid Merit Badge" that inspired him to pursue emergency medicine, subsequently earning the rank of Eagle Scout prior to graduation from Marlborough High, a public school in Massachusetts.

He received his Bachelor of Science in Health Science, Summa Cum Laude, in 2009 where he studied public health, health policy, nutrition, and healthcare systems while obtaining his pre-medical prerequisites. In addition to experience concurrently working full-time as an emergency physician, he also served as an intern at the Commonwealth Connector during a "co-op" rotation, the organization responsible for implementing the Massachusetts healthcare reform, a precursor to

the Affordable Care Act. He received his M.D. from the University of Massachusetts Medical School, in Worcester, MA, in 2013.

Dr. Li's postgraduate residency training included service as a Preliminary Resident Intern at University of Maryland Internal Medicine through 2014. He then trained as an Emergency Medicine Resident Physician at Ascension St. John Hospital Moross in Detroit, MI from 2014-2017. When Dr. Li began his residency at St. John, he trained under physicians belonging to the independent 130-physician emergency physician group "Emergency Medicine Specialists."

Early in this training, in September of 2014, this group was acquired by TeamHealth.[1] In October of 2016, while Dr. Li was a senior resident, TeamHealth was acquired by the private equity firm, Blackstone, for $6.1 billion.[2] In October of 2021, Medpage Today interviewed and reported on a physician who served as one of Dr. Li's Attending Physicians during his training and these acquisitions and continues to practice there, in an article entitled "Is Private Equity a Dangerous Employer?"[3] While training in emergency medicine, Dr. Li also assisted the Wayne County Sheriff's Office SWAT/SRT as a Special Deputy, Tactical Physician, and Medical Director.

Dr. Li was then employed as an Associate EMS Medical Director, as a full-time position and as a hospital employee at the Mercyhealth system in Wisconsin, a non-profit hospital system. He worked there from July of 2017 until November of 2018. He worked in areas including prehospital physician and EMS medical director; 24/7 field-response to assist EMS crews; teaching; QA & QI; and protocol development with multiple EMS agencies; in addition to clinical duties primarily at a critical access Emergency Department.

From 2018 through 2021, Dr. Li was employed as an Attending Emergency Physician, in an independent contractor capacity, serving at various hospitals, locum tenens. Dr. Li made the decision to work as a locum-tenens independent contractor after increasingly coming to the realization that corporate staffing firms, also knowns as Contract Management Groups ("CMGs") were rapidly acquiring or replacing locally owned democratic Small Democratic Groups ("SDGs"), which had been considered to be the ideal way to practice emergency medicine for both patients and physicians. He felt that the arrangement as a locum independent contractor, though not ideal, retained the most autonomy relative to other available employment scenarios in emergency medicine. This work gave Dr. Li experience in a variety of settings, from single coverage critical access, to tertiary centers and community hospitals, with a variety of corporate structures.[4] In this manner Dr. LI's personal experience informs his expert qualifications.

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[1] https://www.prnewswire.com/news-releases/teamhealth-expands-michigan-presence-274652111.html

[2] https://www.reuters.com/article/us-teamhealth-m-a-blackstone/blackstone-to-buy-teamhealth-for-6-1-billion-idUSKBN12V19U

[3] https://www.medpagetoday.com/special-reports/exclusives/95022

[4] By this phase, Dr. Li had started to observe the Corporate Practice of Medicine and problems of small democratic groups, "SDGs." Dr. Li declined to work for a corporate CMG (contract management group) as he learned more about them especially after one experience as an IC via a locum tenens company sub-contracted to an Envision-staffed hospital where he witnessed concerning behaviors.

Dr. Li graduated emergency medicine residency with greater than $300,000 in educational debt compounding at 6.8% interest that cannot be discharged except in bankruptcy. This is not an uncommon debt burden for graduating physicians compounded by the opportunity cost of 4+ years of undergraduate education, 4 years of medical education, and 3 or more years of postgraduate residency training. The heavy debt-load influenced Dr. Li's decision not to pursue fellowship training in critical care and led him to commit substantial time researching personal finance management to not to remain indentured to corporate practice arrangements. Along this journey, Dr. Li was enlightened about private equity involvement in emergency medicine, which at this time happens fortuitously to be an emerging issue, as well as transparent models of care with the "direct primary care" movement at the center. Dr. Li has since lectured on personal finance topics for medical students and other physicians and, how to avoid financial scams by unscrupulous "financial advisors," as well as how to gain financial freedom to avoid being exploited by unethical employers. He believes this financial latitude is necessary to avoid the moral injury when one is forced to transgress deeply held moral beliefs on a recurrent basis when one is reliant on a corporate job in medicine. The term "moral injury"[5] was first adopted by the military and is recognized by the Veterans Affairs National Center for PTSD as a cause of PTSD among veterans and translated to medicine and healthcare by Dr. Wendy Dean and Dr. Simon Talbot,[6] co-founders of the Moral Injury of Healthcare, a 501(c)(3) non-profit.

While becoming more outspoken in venues including social media, Dr. Li became increasingly involved with the American Academy of Emergency Medicine ("AAEM") while studying the history of corporate exploitation in emergency medicine, including the origin of the exploitative business model currently and controversially embodied by TeamHealth, and its competitor, Envision.

The specialty of Emergency Medicine is unique among all medical specialties in that it has two competing specialty societies,

1) the AAEM, and
2) the American College of Emergency Physicians ("ACEP").

The AAEM was formed in 1993 in response to the quasi-fictional book, entitled, The Rape of Emergency Medicine, written in 1992 by the first president of the AAEM, Dr. James Keaney, writing initially under a pseudonym. This book outlined the commodification of physicians to staff emergency departments and the birth of CMGs[7] which, in evidenced instances, began to place profits over patients. In "The Rape of Emergency Medicine," the leadership at ACEP was implicated in these corporate improprieties. Conflicts of interest persisted and arguably worsened at the ACEP over the ensuing 30 years as this initial business model resulted in series of mergers,

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[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6752815/

[6] See materials that are available at https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp#:~:text=A%20moral%20injury%20can%20occur,respect%20to%20their%20moral%20beliefs.

[7] "A contract management group (CMG) holds contracts with individual hospitals with the promise to provide physician services, and it, in turn, employs physicians to fulfill those contracts." https://www.medscape.com/viewarticle/760258_3#:~:text=A%20contract%20management%20group%20(CMG,physicians%20to%20fulfill%20those%20contracts.

acquisitions, and joint ventures, including a sentinel event when the first staffing group aka CMG was sold to a lay-company called Laidlaw, a Canadian-based bus and transportation company in 1997 for $400 million US dollars. This marked the first time that an emergency medicine staffing agency became an asset for an external company not controlled by a physician to generate external profits. Since this acquisition, numerous cycles of private-equity and public ownership have plagued an increasing percentage of emergency departments, exacerbating an already-unethical commoditized/commodified business model that is misaligned with quality patient care. The second president of the AAEM, Robert McNamara, M.D., Chair of the Temple University Emergency Department currently serves as the Chief Medical Officer of the AAEM-Physician Group, the entity with a lawsuit alleging the illegal corporate practice of medicine by Envision, the corporate counterpart to TeamHealth in California. Dr. McNamara currently serves as an advisory board member of Take Medicine Back, PBLLC.

In 2020, Dr. Li founded Thrive Direct Care, PLLC with a growing recognition that transparency is needed to practice medicine ethically, and that increasing corporate control through hospitals, consolidated insurance companies, and private equity owned staffing groups are harming patients and physicians alike, making the ethical practice of medicine difficult if not impossible when participating as an employed physician. Thrive Direct Care a direct, affordable, subscription-based medical care service with transparent pricing, and providing access to wholesale imaging and lab testing, with a focus on uninsured and self-employed individuals. While researching, organizing, founding and treating patients through the practice, Dr. Li has gained additional experience regarding the business and economics aspects to medicine. He is in the process of publishing a book tentatively titled "How To Hack Your Healthcare," designed to benefit patients directly in order to teach them how to obtain the highest quality of care while avoiding financial pitfalls and predatory billing practices of all corners of the healthcare industry – from pharmaceuticals to hospital over-billing, to low-quality of care incentivized by fee-for-service, insurance-based primary care that underlies the "fast food, move the meat" industry that has threatened what was once a respected profession of medicine. Dr. Li continues to practice in this model with a limited number of patients while also actively practicing as an emergency physician.

After widespread pay and staffing cuts were implemented by ED staffing groups and hospitals despite CARES ACT bailouts (that in certain respects benefited corporations but not patients or frontline physicians),[8] during the summer of 2021, Dr. Li, a 1099 contractor, was removed from the schedule from his primary hospital site. He subsequently focused his efforts on organizing and producing the TakeEMBack Summit in October of 2021 (available on YouTube[9]) prior to relocating to Western North Carolina in December of 2022.

Beginning in March 2022, Dr. Li began serving a historically underserved and marginalized Native American population as an independent contractor and subsequently as an

[8] https://www.propublica.org/article/medical-staffing-companies-owned-by-rich-investors-cut-doctor-pay-and-now-want-bailout-money; https://www.propublica.org/article/coronavirus-er-doctors-nurses-benefits; https://www.statnews.com/2020/04/01/slashes-benefits-for-doctors-coronavirus/; https://www.alreporter.com/2020/04/09/er-doctors-in-frontline-battle-against-covid-19-are-facing-pay-cuts/; https://www.cnn.com/2020/04/08/politics/emergency-doctors-hospitals-losing-pay-covid/index.html; https://ourfinancialsecurity.org/2021/09/report-public-money-for-private-equity-cares-act/.

[9] https://www.youtube.com/watch?v=i1O5J_Yu2sI&list=PLoYGxTS98F1NMzTdws5Q9kITQ_aamPSGA

employed Attending Emergency Physician beginning in June 2022 at the Cherokee Indian Hospital, where he has a full range of duties.

The Cherokee Indian Hospital is the primary medical home for over 11,000 members of the Eastern Band of the Cherokee Indians ("EBCI"), the remaining members of the tribe native to modern-day North Carolina who were not relocated during the "Trail of Tears," also known as the "Indian Removal." Cherokee Indian Hospital provides over 18,000 yearly primary care visits. It also accommodates more than 22,000 ER visits per year. The CIHA satellite clinics include the Cherokee County Clinic, the Immediate Care Center, and the Snowbird Health Clinic, along with the Analenisgi Recovery Center and the Kanvwotiyi Residential Treatment Center.[10]

Western North Carolina is dominated by the Hospital Corporation of America ("HCA") as well as Duke LifePoint, a hospital system that is fully owned by the private equity firm Apollo Global Management, which is controversial for making $1.6 billion by selling LifePoint to another fund it owns.[11] Duke LifePoint, including both Haywood and Harris hospitals, contracts with TeamHealth, in an arrangement that may be unlawful under the North Carolina state-law and regulatory prohibitions on the Corporate Practice of Medicine (previously short-formed as CPOM). The result of this is a labor monopsony that leaves emergency physicians in the community with few employment opportunities if they are blacklisted from TeamHealth or do not wish to work for what they may perceive to be a morally[12] compromised HCA/TH institutional structure that violates prohibitions on the corporate practice of medicine.

In 2021, Dr. Li founded the public benefit organization called Take Medicine Back, PBLLC.[13] This is a public benefit company with the charge to produce a public benefit by operating in a responsible and ethical manner and by imparting education and advocacy to the public regarding the evolving medico-legal subject area known as CPOM. A focus of this group has been on researching and addressing concerns regarding the financial exploitation of patients and the erosion of trust between physicians and patients – and between physicians, other healthcare workers, and non-physician practitioners. The first "TakeEMBack" summit, focused on emergency medicine, was organized by Take Medicine Back and held virtually in October of 2021. The videos from this summit are now available on YouTube on the Take Medicine Back YouTube Channel.

Dr. Li has also been active with the American Academy of Emergency Medicine ("AAEM"), Locum Group ("AAEM-LG"). Assisting as a Chief Medical Officer, he has translated what he has learned through experience regarding the obscure and the unethical practices employed by many locum-tenens companies and helped develop the AAEM-LG to establish fair and transparent work opportunities for emergency physicians in the locum tenens marketplace. Dr. Li was pleased to be appointed to this service position by the AAEM Board of Directors. Dr.

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[10] https://cherokeehospital.org/locations/.

[11] https://www.beckershospitalreview.com/finance/pe-firm-made-1-6b-by-selling-lifepoint-to-fund-it-owns.html

[12] Unlike in some other areas of endeavor, human morals are relevant for medicine. Th humanistic and Samaritan aspect of medical care is one of the reasons why society seeks to protect the core scope of a physician's independent individual professional judgment and competence. But for the impairment of this core independent judgment that due to CPOM violations occurred here, the relevant overbilling would not have happened.

[13] https://www.takemedicineback.org/

Li was appointed to the AAEM-Physician Group Board of Directors to help them achieve their goal of expanding the AAEM-PG and incorporating an AAEM-LG to further the vision of a fair and transparent work environment for emergency physicians.

Of note, the AAEM-PG embodies what Dr. Li and the AAEM feel to be an ideal and practical alternative to the unethical corporate practice of medicine within the confines of the broader system of the United States healthcare milieu. This ethical practice model is practical so long as anticompetitive behaviors of consolidated hospital systems that prioritize profits over patients are not tolerated, and existing prohibitions on the corporate practice of medicine are enforced. The AAEM-PG is a practice management group, wholly owned by the non-profit, the AAEM, that "empowers local, independent, democratic emergency physician groups to meet their full potential."[14] The AAEM-PG has high standards for transparency, and fairness where each physician is an owner to provide the highest level of care and are most invested in the long-term success of the community. Values include "financial fairness and transparency", "due process and post-employment fairness", and "partnership, political equity, and transparency" that empower individual physicians who take an oath to patients to have control over their practice, including determining what is felt to be appropriate staffing, time with patients, and what protocols (if any) should be employed.

Dr. Li has also had other professional involvements that have assisted him in obtaining a thorough understanding of CPOM issues. He has co-authored various position statements and relevant white papers and articles. For example, in 2020, he co-authored a position statement on self-supplied personal protective equipment ("PPE") touching on power relations as between hospital corporations and physicians and hospital staff. Dr. Li also recently assisted in creating the AAEM-ACEP Joint Statement on COVID physician misinformation. Dr. Li also published the op-ed "How Private Equity Is Ruining American Healthcare" in Medpage Today in July of 2021.

Dr. Li has had other involvement in public policy matters regarding the changing landscape of emergency department practice, ethics and employment issues. In January of 2021, Dr. Li was interviewed as part of a panel on KQED's "Forum" hosted by Alexis Madrigal alongside professor of health economics at UC Berkeley Richard Scheffler and Pulitzer-prize winning NBC News journalist Gretchen Morgenson. In April of 2021, Dr. Li was invited to speak as one of eight invited speakers and one of only three physicians at the Federal Trade Commission and Justice Department Listening Forum on Firsthand Effects of Mergers and Acquisitions: Healthcare. His testimony was cited in The Millbank Quarterly's, quarterly opinion, "Antitrust Enforcement in Health Care Is No Longer a Pipe Dream." Prior to this, Dr. Li's advocacy group, Take Medicine Back, ran a social-media-based campaign encouraging physicians to share their stories with the Federal Trade Commission's docket on healthcare mergers, leading to a headline on March 23, 2022 in Law360 "Doctors' Worries Over PE Deals Dominate Merger Comments" and specifically citing Take Medicine Back as well as the official letter submitted to the FTC by his organization. Please see his CV for additional information.

Dr. Li is Board Certified in Emergency Medicine.

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[14] https://www.aaemphysiciangroup.com/about-us

3. CPOM – The Corporate Practice Of Medicine – and its applicability herein.

As is discussed further below, this case with its allegations of over-care (also called over-calling, over-triage, over-ordering) implicates CPOM.

The underlying qui tam allegations concern the following topics, among others:

Over-prescribing/over-ordering of laboratory sample collections, metabolic panels and other laboratory analyses of samples; unnecessary urinalysis samples and analysis of samples; medically unnecessary ordering of CT Scans, x-rays and ultrasounds, and other care items, supplies and services, unnecessary hospital admissions and specialist consultations.

Designating patients as Code Trauma, Trauma Alert, Code Sepsis, or Geri Trauma when that was not medically necessary, and in turn it overbilled the government. And,

Notional supervision: That is, the concept that HCA and TH have structured the ED such that physicians are not truly and substantively able to actively and meaningfully supervise the staff of far more prevalent non-physician practitioners (PAs, NPs, other non-physician practitioners who are not doctors).

This unlawful practice causes overbilling, which is illustrated, for example, in a prior qui tam matter. See the lawsuit entitled *United States v Team Fin., LLC*, aka the *Hernandez* case. There, an FCA claim alleged a "mid-level-scheme" where TeamHealth overbilled for services provided by "mid-level" practitioners. CMS reimbursed "mid-level" services at 85% of the standard physician rate, while services rendered by a physician were reimbursed by 100% of the standard physician rate. The lawsuit alleged in part: "TeamHealth, through its billing policies, procedures, and protocols (which include training and guidelines), and through its coordinated operations and influence over its subsidiaries and affiliated professional entities—systematically submits claims for mid-level services under various physicians' NPIs (as assigning charts to a physician by a midlevel is usually based on shift assignment and how shifts overlap), triggering the 100% rate when in fact the 85% rate applied. TeamHealth does this intentionally and has done so for years." Thereby, TeamHealth was effectively defrauding the federal government on a regular basis.

Notional supervision has not been legally defined. The term, coined by board-certified emergency physician and direct primary care physician Megan Galer, M.D. in the Reclamation of Emergency Medicine White Paper, refers to supervision that is "in name only" and otherwise meaningless. It is distinct from state-based legal requirements for supervision which may or may not reflect the professional expertise and judgment of a trained and licensed physician (MD or DO). For instance, in North Carolina, the current legal requirements for supervision are extremely lax and include one meeting every six months with a supervising physician for nurse practitioners. Depending on the context, this supervisory arrangement is entirely meaningless aka "notional," in name only, in terms of assuring safe, efficient, and quality patient care. The pending SAVE Act, passed in the NC Senate in an omnibus bill with Medicaid Expansion, would further exacerbate an already notional supervisory requirement by eliminating all oversight and supervisory requirements by nurse practitioners, opening the door for unfettered exploitation of patients and

non-physician practitioners by enabling the unlicensed practice of medicine further exacerbated by corporate profiteering and financial engineering such as via the leveraged buyout industry aka "private equity." Of note, TeamHealth is owned by the largest private equity firm in the world, Blackstone, and chaired by the infamous Stephen A. Schwarzman who is currently worth $28.9 billion dollars (a figure that nearly tripled from pre-pandemic) and is particularly well-known for his outlandishly expensive birthday parties featuring Gwen Stefani, camels, and Chinese acrobats.[15]

The Corporate Practice of Medicine -- A central tenet regarding CPOM is the definition of "practicing medicine" as discussed in the definition of the "Practice of Medicine." In a recorded[16] interview entitled "Families sound alarm on medical transparency after deaths of their children," Sophia Thomas, then the president of the American Association of Nurse Practitioners ("AANP"), when confronted by the news anchor asking the question "do nurse practitioners practice medicine? responded "we practice healthcare." The AANP makes no secret that it is funded by corporations including one or more that are frankly invested in low-cost "prescribers" that are easy to influence, funded by vertically integrated insurance companies, a vast array of pharmaceutical companies, and vertically integrated pharmacy-benefit management companies that behave as cartels, increasing the cost of needed pharmaceuticals and decreasing access to medications critical to American citizens.

The AAEM defines CPOM as occurring "whenever a non-physician individual or corporation exerts control over medical decision-making or collects reimbursement for the medical services of physicians."[17]

The position of the North Carolina Medical Board is as follows in its policy statement dated March 2016:

> 10.1.2: Corporate Practice of Medicine
>
> It is the position of the Board that, except as discussed below, businesses practicing medicine in North Carolina must be owned in their entirety by persons holding active North Carolina licenses. The owners of a business engaged in the practice of medicine must be licensees of this Board or one of the combinations permitted in N.C. Gen. Stat. § 55B-14. Licensees of the Board providing medical services on behalf of businesses engaged in the corporate practice of medicine may be subject to disciplinary action by the Board. Whether a licensee of the Board is an employee or independent contractor is not determinative of whether a licensee is aiding and abetting the corporate practice of medicine. In addition, the Board may seek injunctive relief against lay owners of businesses engaged in the corporate practice of medicine.

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[15] See https://money.com/reports-trump-economic-advisor-throws-multimillion-dollar-birthday-bash-with-camels-and-gwen-stefani/.

[16] https://www.youtube.com/watch?app=desktop&v=hNngiwQC29c&t=1s&fbclid=IwAR0D-UWpuhs-sVIDxJnIleGdm4CL4k_yJZYGXinGJd2R7bSdo9FxQm46_Ww

[17] https://www.aaem.org/resources/key-issues/corporate-practice.

(Emphasis added). In its contracts (unilateral, take-it-or-leave-it contracts of adhesion) with individual physicians, Team Health requires the physicians to agree to contract provisions stating that the physicians are only independent contractors. But the underlined language above means that Team Health cannot insulate itself from liability by using such contract language. The policy goes on to state:

> The Board does recognize certain exceptions to the corporate practice of medicine, including hospitals and health maintenance organizations. Such exceptions are premised on the notion that these entities are statutory creations intended for the public welfare and regulated by the government, thus ameliorating the inherent conflict between profit-making and good medical care. Under a similar rationale, public health clinics and charitable nonprofits are also considered exceptions to the prohibition on the corporate practice of medicine.
>
> Hospital-Owned Practices
>
> As mentioned above, the Board recognizes an exception to the prohibition on the corporate practice of medicine for **non-profit** hospitals and in turn medical practices that are owned by such hospitals. The policy underlying this exception is that non-profit hospitals are charged with the same mission as the Board in protecting the well-being of the citizens of North Carolina. In keeping with this policy, it is the Board's expectation that hospital-owned practices will recognize the ethical obligations that their licensed employees have to their patients and allow them to discharge such obligations. For example, it is the position of the Board that licensees who depart such practices for reasons other than safety concerns be permitted to provide appropriate notice to their patients, ensure continuity of care, and allow patient selection.

(Emphasis added).[18] Here, neither HCA nor Team Health are nonprofit entities.

Here, due to notional supervision, corporate metrics, corporate decisions regarding staffing, corporate-driven standard operating procedures (SOPs), non-physician decision makers are making the decisions. For instance, a lecture given by the Envision "chief innovation officer," Kirk Jensen M.D., at a TeamHealth-funded "emergency medicine directors academy" hosted by the ACEP, emphasized that one should employ the "least expensive resource to accomplish the 'mission'" and that "SOPs and advanced treatment protocols, developed and implemented with nursing's participation, can drive efficiency and reduce variation." The "variation" referred to here is the expertise of a physician who can provide personalized, high-quality care. "Efficiency," as defined by a company owned entirely by a private equity firm engaged in monopolistic and monopsonistic behavior, is quite opposed to the definition that may be adopted by a society that values high-quality care. Further, the "mission" alluded to in the presentation and slide can be equated to the mission of TeamHealth, owned in full by the Blackstone firm – to produce returns for private equity investors – not quality care for patients.

[18] https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/corporate-practice-of-medicine (last accessed 6/17/22).

By this mechanism, for example, emergency physicians have been rendered powerless to protect their patients from inappropriately utilized, lesser-trained practitioners. Coercive arrangements whereby emergency physicians are essentially forced to engage in "notional supervision" agreements with non-physician practitioners ("NPPs") as a condition of employment are pervasive in emergency medicine while also placing the physician in the unfortunate scenario of acting as an unwitting liability lightning rod.

NPPs are often hired by CMGs[19] in lieu of physicians in order to decrease overhead, directly increasing returns for their investors. A pitchbook presentation obtained from another private equity owned staffing group, American Physicians Partners ("APP"), exposed a pitch to investors to increase profits by exploiting an expected over-supply of emergency physicians as well as to implement "staffing mix changes" by shifting "staffing between MDs/MLPs to align with volume trends" in addition to "overall staffing reductions." This business model manipulation came in the context of receiving $23 million in total CARES Act funding, further defrauding the federal government. These NPPs are, in many cases, working outside their scope of practice.

In agreeing to "supervise" the NPPs in name only (i.e., via uncompensated retrospective chart review or from an off-site location), not only are physicians made complicit in this pretextual compliance activity and potentially endangering patients, but they are also being forced into positions where they are affected by CPOM. The blame for this lies not primarily with the physicians, but with the CMGs who actively disincentivize proper supervision.[20]

A non-physician, according to Dr. Ramming and Dr. Lalor, in many instances, is deciding whether patients should be Code Trauma. A non-physician (namely HCA, the for-profit corporation), made a policy change resulting in most incoming patients going into the Mission Asheville emergency department – under the old policy pre-HCA, incoming patients depending on their circumstances could either go to the ER or to an inpatient bed. Non-physician practitioners without adequate access to physician consultation or backup are exploited by HCA and TH as lower cost alternatives to physicians. These NPPs[21] routinely order medically unnecessary labs, scans and other care, supplies and services – which all get billed to Medicare and other payers.

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[19] CMGs are defined in the White Paper: "Nonetheless, emergency physician staffing groups are increasingly being voluntarily sold for exorbitant personal profit, or hostilely ousted by PE-backed contract management groups (CMGs). As of 2021, an estimated 50% of emergency physician jobs are through large, PE-owned CMGs. The standard five- to seven-year life cycle of a PE-leveraged buyout places enormous pressures on companies to expand rapidly, aggressively increase revenue, and cut operating costs. In the field of emergency medicine, 'cutting operating costs' usually means decreasing staffing or replacing emergency physicians with lower-cost labor, often at the expense of patient safety. Why do so many emergency physicians continue working for these CMGs despite such ethical qualms? Simply put, they don't see any viable alternatives." From Mitchell Louis Judge Li MD, Robert McNamara MD, Natalie Newman MD, Meghan Galer MD, "Aayla Secura" MD, The Reclamation of Emergency Medicine: "Take EM Back," White Paper.

[20] From Mitchell Louis Judge Li MD, Robert McNamara MD, Natalie Newman MD, Meghan Galer MD, "Aayla Secura" MD, The Reclamation of Emergency Medicine: "Take EM Back," White Paper.

[21] Unfortunately, this very descriptor has become somewhat weaponized. Defendants prefer the nomenclature of "providers" or "advanced practitioners" – a term that sounds like it could mean superior to doctor. In fact, a Nurse Practitioner is a Nurse. An NP or PA is a nonphysician practitioner, sometimes called a midlevel. The term "non-physician practitioner" could accurately go to describe that group.

The emphatic use of SOPs by TeamHealth and other corporate staffing groups is a powerful application of ***choice architecture*** to influence (medical) decision making. In the field of behavioral economics, choice architecture is a deliberate design of different ways choices can be presented to decision makers in order to impact that decision making. If, for example, the "default" is that a corporate protocol is initiated according to overly liberal criteria (e.g., sepsis criteria or trauma or geri-trauma criteria), then even if the physician or non-physician clinician has the theoretical ability to cancel or go against the protocol, behavior would be systematically swayed toward over-ordering and over-activating of over-sensitive protocols. Another way to think about this is in terms of sensitivity and specificity. If the criteria to trigger a protocol (e.g., trauma, geri-trauma, sepsis) is overly sensitive, specificity is sacrificed and a glut of "false positives" result. A false positive is an error in which a test result or screening criteria incorrectly indicates the presence of a condition (for example, sepsis or septic shock, or trauma requiring the workup or interventions necessitated by HCA and TH protocols without the input of the emergency physician). A certain degree of false positives are acceptable with any imperfect test. However, Dr. Li will testify that after reviewing the testimony of Drs. Ramming and Lalor, that criteria broadened after HCA and TeamHealth takeovers would clearly result in an unacceptably high false positive rate, along with resultant over-ordering of labs, imaging, and ancillary services and their associated over-charges.

According to Dr. Ramming's testimony, he was involved in the development of some sepsis "power plans" prior to what he now testifies as HCA's and TeamHealth's overuse of them. In the field of behavioral economics, "libertarian paternalism," where people (typically a population and not a profession or expert) are "nudged" to make decisions that are felt to be in the best interest of society and is considered ethical when autonomy is left to easily "opt out" of a default option. Dr. Lalor's and Dr. Ramming's testimony makes it clear that the effect of the "nudges," in the cases of sepsis power plans and trauma alerts, is to nudge behavior to benefit profits of TeamHealth and HCA (and not society). Furthermore, the board-certified emergency physician, an expert, is unable to "opt out" when labs or imaging are already completed by protocol or non-physician practitioner. It becomes clear to Dr. Li in reviewing Drs. Lalor and Ramming's testimony that physicians at TeamHealth and HCA have been repeatedly reminded or even harassed by administration to make overuse of power plans and protocols in order to serve revenue-driving corporate metrics and broad overuse, and not quality patient care. Taken together, the inappropriate use of choice architecture, coercion, and lack of autonomy for the recognized experts in emergency medicine to exercise their independent medical judgment for the benefit of quality patient care and to be a steward of public resources, including Medicare, constitute the corporate practice of medicine in no uncertain terms.

EMTALA violations and Medicare overbilling.

Another substantial issue referenced by the complaint is "having in practical terms unsupervised non-physician practitioners perform purported EMTALA medical screening examinations which may be unreliable under the circumstances." EMTALA is the Emergency Medicine Treatment and Labor Act, a federal law enacted by congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 that requires anyone presenting to an emergency department in the United States to be entitled to, at minimum, a medical screening exam (MSE) to screen for an emergent condition.

This applies to Medicare-participating hospitals with emergency departments. If an emergent condition is identified, the patient is entitled to stabilization and treatment regardless of their insurance status or ability to pay.

The question of who is qualified to perform and what constitutes an "appropriate" MSE is not defined by COBRA. Given the use of the word, "medical", however, would imply that only one who is qualified the practice medicine would be qualified to determine what constitutes an appropriate MSE and who is qualified to perform it. The most qualified physician in the emergency department is the board-certified emergency physician, a physician licensed to practice medicine and who has specialty training of at least 3 years in a program accredited by the Accreditation on Graduate Medical Education (ACGME), and who has passed board certification examinations.

While it is not clear that a board-certified emergency physician is required to satisfy the requirements of EMTALA, it is clear that they would be the most qualified to determine who is qualified and in what circumstances. Here, it appears that TeamHealth, a corporation not qualified to practice medicine, determines staffing to place a "Triage Advanced Practitioner" referred to as a TAP *and* implements certain Standard Operating Procedures (SOPs) directing protocolized workup *and* determines the total number of staff potentially leading to insufficient time for an appropriate MSE to be performed even by a qualified individual. Based on this CPOM intrusion, the potential for widespread EMTALA violations exists as well as a risk of simultaneously overbilling Medicare and Medicaid.

Relatedly, a corporation such as TeamHealth is not qualified to determine who is qualified to perform an MSE, under what circumstances an MSE can be performed (e.g. what constitutes enough time to perform one for a given person or level of training), or what constitutes an "appropriate" MSE.

In short, the preliminary facts support the conclusion that the placement of non-physician practitioners in triage by the defendants leads to *inappropriate* workups and evaluations which both cause over-billing of the government and do not constitute an appropriate MSE.

In some, or perhaps many cases, a "TAP" may be the only evaluation a patient receives. Corporate metrics often track "Left Without Being Seen" or LWBS. These are patients who have checked in to the ED, but left before an MSE, often due to long wait times. When a patient is seen by a "TAP", EMTALA is considered fulfilled by TH and HCA, and LWBS metrics are deemed to be improved.

In reality, however, an MSE may not have been performed by a qualified individual, may not have included an "appropriate" exam and may have been performed under impossible circumstances under a "time-pressured, brief-interaction scenario" as described by the Relators, in which even the most qualified board-certified emergency physician may not be able to adequately perform an MSE.

In addition to resulting in widespread over-billing of Medicare and the government, the illusion of an MSE can also be devastatingly dangerous to patients who may leave the department

with a false sense of reassurance that a qualified individual evaluated them for a medical emergency medical condition.

Further substantiating the concern that non-qualified personnel may be performing unsupervised MSEs is an Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in the U.S. Emergency Departments published in the nursing literature the Journal of Nursing Regulation in January of 2022 which concludes that "Extensive variability exists across the academic preparation of NPs working in the ED setting as well as in the licensure and certification requirements governing NP practices in EDs. Until this variability is resolved, we conclude that NPs should not perform independent, unsupervised care in the ED regardless of state law or hospital regulations in order to protect patient safety."[22]

While limited resources such as the lack of availability of board-certified emergency physicians such as in rural areas may reasonably limit the practical availability of the most qualified personnel to perform an MSE, Mission hospital is located in Asheville, NC, a highly desirable location in Western North Carolina which should have no difficulty in attracting highly qualified personnel due to geography. Further, the American College of Emergency Physicians recently published a report predicting an impending over-supply of board-certified emergency physicians by 2030 with the Annals of Emergency Medicine predicting a surplus of 7,845 emergency physicians by 2030.[23]

As noted previously, TeamHealth has a labor monopsony in western North Carolina both through joint ventures with the dominant HCA system as well as Duke LifePoint. Also of interest is that HCA touts being the largest sponsor of graduate medical education in the country contributing to an over-supply of emergency physicians.[24] Taken together, the impending oversupply of emergency physicians, the contribution to this over-supply by HCA, and the general maldistribution of board certified emergency physicians away from rural areas and toward desirable locations such as Asheville, NC make it clear that there is no excuse not to allow board certified emergency physicians decide the appropriate staffing model to provide a medical screening exam and staff the emergency department more broadly.

In some cases, a patient may wish to decline an MSE. There is no violation if a patient refuses examination and/or treatment unless there is evidence of coercion. At some hospitals, an RMSE or "refusal of medical screening exam" is documented. An example appropriate use of an RMSE might be when a patient is asked to meet their specialist physician in the emergency department for evaluation or a procedure. In this case, the patient has access to a well-qualified physician and is not in need of an additional MSE and may reasonably decline one. If a patient is not given an option to refuse or decline an MSE, this may incur excess charges to the government by TeamHealth. Similarly, a patient who is evaluated by a "TAP" but is never roomed, never evaluated by a physician, or adequately evaluated by a non-physician practitioner may be charged for an MSE without either the opportunity to decline it, or with an exam that does not meet the standards of an "appropriate" MSE.

[22] https://www.sciencedirect.com/science/article/abs/pii/S2155825622000102. And see https://www.journalofnursingregulation.com/article/S2155-8256(22)00010-2/fulltext.
[23] https://www.annemergmed.com/article/S0196-0644(21)00439-X/pdf
[24] https://www.takemedicineback.org/statement-on-emergency-medicine-match-2022

Meanwhile, HCA and TH – using business models optimized for corporate profit not for patient care – take control of all medical coding and billing and make that a black box, inaccessible to the physician. And HCA and TH make doctors "sign off on" and approve dozens of electronic patient charts per shift that NPPs did the work on, and HCA and TH fail to give or compensate the physicians for the time they would need to truly supervise, monitor or audit these NPPs.

This constitutes the CPOM and overbills the government while contributing to a lower quality of care for patients and society.

Furthermore, it is illegal and unethical conduct per industry standards. Medical billing based on unlawful conduct is fraud.

Additional preliminary observations.

The generic employment agreements that the physicians enter with the Team Health owned entity include provisions a) requiring the physician to accede to TH using its own HCFS division for coding and billing; B) not allowing the physician to be able to access transparently the coding and billing data; and C) nonetheless, purporting to make the physician liable for any problems in billing – see agreement at numbered paragraph 19: "Professional agrees that Professional shall abide by any and all current and future applicable laws ... including, without limitation ... those regarding ... **billing**." (Emphasis added).

It is agreed in the same contract that the doctor (the "Professional" per contract language) was <u>not</u> the one to do (or indeed to know anything about) the billing. Instead, the "Company's designated billing company or other entity [here, HCFS] shall be entitled to bill and collect for Services rendered by Professional free and clear of any claim by Professional." (Para. 8).

Further, egregiously, the purported form contract with the physicians recites that "Professional hereby indemnifies . . . Company" and its "agents" from any damages from liability for "violation of the applicable corporate practice of medicine [sic]." The full quote is:

> Professional hereby indemnifies, holds harmless, and agrees to defend Company, its directors, officers, employees and agents (the "Company Indemnitees") from and against, and in respect to, any and all losses, damages, liabilities and expenses, including, but not limited to, reasonable attorney's fees, which the Company Indemnitees may suffer or sustain, or be threatened with liability for, arising as a result of Professional's corporation formation, corporate structure, <u>violation of the applicable corporate practice of medicine</u> [sic], and conduct of business in the State.

(Contract, para. 23, emphasis added). It reads as a threat to the physician, a deterrent to precisely the instant kind of protected conduct by which Dr. Ramming and Dr. Lalor have acted as "whistleblowers" by reporting improper conduct to the U.S. and N.C. state government. This is a time in which our Medicare and Medicaid benefits are jeopardized for many of us. The U.S. Social Security, Medicare and Medicaid programs are in danger of running out of money. Ordinary citizens have paid in tens of thousands of dollars taken out of their paychecks across decades --

and now, they have to face the danger that maybe, their hard-earned benefits from Social Security, Medicare, and Medicaid, will run out. When the Medicare program needs to save every dollar that it can for the benefit of taxpayers and society, it is simply unacceptable that any company in the healthcare area engages in conduct that overbills the program. A brave whistleblower should be safeguarded, respected and protected, never threatened with having to somehow "indemnify" all of Team Health's possible "agents" if in fact Team Health was engaging in the unlawful corporate practice of medicine.

The American Medical Association explains that the majority of states prohibit the corporate practice of medicine. It is important to understand that the CPOM doctrine has been shaped by three broad concerns:

> "(1) Allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine,
>
> (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his patients, and
>
> (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment."[25]

(Emphasis added).

It should be noted that TeamHealth is not owned by an ordinary corporation. It is owned by the largest private equity firm in the world, Blackstone. Private equity is a poorly named (possibly by design) rebrand of the "leveraged buyout industry" characterized by investments typically spanning 4-7 years by a general partner ("GP") at the firm and limited partners ("LP") such as pension funds and wealthy individuals that purchase an asset (in this case TeamHealth) with significant high-interest debt, but instead of owning the debt and therefore the risks of said debt, the debt is placed on the company itself, creating enormous pressures to rapidly and ruthlessly increase revenue while cutting costs and quality. The risk of failure and default on loans is borne by the labor of private equity owned companies as well as society. The GP in this scenario takes on virtually no risk as they earn assets under management regardless of outcome in what has been described as – in its worst manifestations -- a "heads I win, tails you lose" wealth extraction scheme and billionaire factory.

The point is that private equity is profit-motive to the max, and therefore, exactly what the CPOM legal armature is intended to protect physician judgment from. If there were ever an ownership structure that prohibitions on the corporate practice of medicine laws were meant to protect patients and society from, it is private equity ownership. Private equity ownership seen through this lens is antithetical to the practice of medicine. The American Antitrust Institute recently concluded that "The private equity business model is fundamentally incompatible with a

[25] https://www.ama-assn.org/health-care-advocacy/state-advocacy/business-medicine.

stable, competitive healthcare system that serves patients and promotes the health and wellbeing of the population."[26]

Through a series of deceptive legal loopholes and shell corporations, CPOM laws have been circumvented in many states and are causing widespread harm to the healthcare system and patients.[27]

Defendants know that the CPOM rules exist. That is the reason why they put form language in the employment contracts for physicians as discussed.

The form language in the employment contracts for TeamHealth at Mission hospital calls the doctor an "independent contractor," but then it states that the doctor will follow "the agreement(s) between Company or its affiliate and Facilities." (See contract attached as an Exhibit to Dr. Ramming's Summary). So, the doctor is supposed to agree to follow whatever terms are in TH's agreement with HCA. But there is no evidence that the doctors are ever allowed to see that contract.

The contract says the doctor will follow "all applicable laws, rules and regulations." However, the companies put the physicians in an impossible position where they cannot abide by CPOM principles and company policies at the same time. This causes enormous stress.

Further, "paper owners" are instrumental to this scheme.[28] They are individuals who maintain an M.D. and physician status and who aid and abet the illegal corporate practice of medicine by lending their medical license and/or degree so as to make it appear that a medical group is owned by a physician when in fact the corporation (e.g., TeamHealth) or its owner-in-full (the Private Equity firm, Blackstone), remains in actual control.

A particularly egregious example of this was exposed during discovery of a wrongful termination case of a physician, Ray Brovont, terminated by TeamHealth counterpart Envision. It was discovered that Dr. Gregory Byrne had been the owner of up to 300 emergency practices tied to Envision or EmCare. "Byrne had been hired and paid by EmCare to be the owner, on paper, of the physician practice running the emergency department that Brovont directed at Overland Park." (See reporting by Gretchen Morgenson of NBC News in Mach of 2022).[29] "Paper Owners" provide the appearance of physician-ownership to the state medical board and secretary of state. According to Dr. Li, private equity executives from the firm Welsch Carson, Anderson, & Stowe have been known to refer to their paper owners as "captive physicians", according to a PE

[26] https://publichealth.berkeley.edu/news-media/research-highlights/study-finds-private-equity-investment-undermines-a-stable-competitive-healthcare-industry/. And see https://www.antitrustinstitute.org/work-product/study-finds-private-equity-investment-accelerates-concentration-and-undermines-a-stable-competitive-healthcare-industry/

[27] https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills

[28] See memo prepared by Robert McNamara, entitled "TeamHealth's contractual structure violates the prohibitions on the CPOM," 1/4/2020. See also Propublica Article, "How Rich Investors, Not Doctors, Profit From Marking UP ER Bills" which implicates TeamHealth specifically. Available at https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills.

[29] https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975.

executive with a previous ownership stake in US Acute Care Solutions (USACS), another large corporate emergency staffing group.

At HCA Mission Hospital, Michael Corvini, M.D. is listed as the President and Executive Director of "Emergency Coverage Corporation", the entity that one will find listed on the paychecks of physicians staffed by TeamHealth at HCA Mission hospital. (See Ramming contract, Ex. 1 to his Relator Summary). Given the known Medical Board protocols, Dr. Corvini would have had to certify presumably that this entity was owned in its entirety by persons holding active North Carolina licenses, and based on the facts regarding the TeamHealth structure, Corvini may be aiding and abetting the corporate practice of medicine in North Carolina. Dr. Corvini is listed as President of the Southeast Group of TeamHealth and, according to the TeamHealth website "…works closely with hospital clients to ensure healthy business relationships and lead all aspects of the group's business, including financial solvency and revenue generation…."

In a memo prepared by Robert McNamara, MD, MAAEM, Past President of AAEM, Dr. McNamara explains that "sham" professional associations are created and that the "paper owners" of TeamHealth are required to sign a Stock Transfer Restriction Agreement at the time of accepting ownership of the professional association. "TeamHealth can terminate their ownership at their whim. The 'paper owner' generally does not practice medicine at the clinical site and has no oversight of the financial, contractual or operating aspects of the physician practice. Each of these physicians signs the TeamHealth Code of Conduct which requires them to advance the interests of this lay corporation."

In fact, any licensee of the board providing services on behalf of a business engaged in the corporate practice of medicine may be subject to disciplinary action by the NC Board of Medicine. However, given that TeamHealth holds a labor monopsony in western NC, the population of Western NC would be virtually without emergency care if licensees refused to provide services to TeamHealth.

Also, the generic employment contract says that the doctor will "exercise Professional's independent professional medical judgment" – which is once again impossible to do, but by including that language in the contract, the companies make the physicians feel guilty and that they may be liable to the company – precisely for following all the corporate rules. Those rules severely and unlawfully compromise and impair the independent medical judgment of licensed physicians.

Dr. Ramming's contract recites that it is "without a right to a due process hearing." (Ramming Summary, Ex. 1, paragraph 4, "Term"). He also describes how classification as an employee or a contractor for tax purposes appeared arbitrary. (Ramming Summary ¶ 108). One element that should not be overlooked is a lack of due process inherent in the misclassification of TeamHealth physicians as 1099 independent contractors. The AAEM asserts that due process is one of the most critical issues facing emergency physicians today. In their white paper on due process, AAEM concludes that "Physicians have a duty to advocate for their patients, even when such advocacy requires opposition to hospital interests." "Unfortunately, some hospitals and contract management organizations attempt to deny physicians their due process rights. This widespread practice threatens physician autonomy." Physicians seek to practice free of corporate

influence. In some cases, physicians are explicitly forced to sign away due process rights as a condition of employment that are otherwise afforded to them by the Fourteenth Amendment of the U.S. Constitution, the Health Care Quality Improvement Act of 1986 (HCQIA), and the Joint Commission. In the case of TH and HCA, one mechanism of bypassing due process rights is simply to claim that the physician was never "employed" in the first place due to 1099 independent contractor status, thus short-circuiting due process rights that should otherwise be afforded to them. In this regard, the nature of ED practice reflects the need for due process. ED physicians interface with patients under unique conditions. Medicare and Medicaid patients, along with the America's uninsured, constitute some of the most vulnerable patients in society. Emergency physicians have a heightened duty as they care not only for the most vulnerable patients but also during their most vulnerable moments.

By denying due process rights to physicians through TeamHealth's classification of emergency physicians as 1099 contractors, and HCA's contracting with this corporation, and the use of "no due process" provisions, TeamHealth and HCA have engaged in conduct that has raised concerning issues. Further, given the national footprint of HCA and TH and their regional market power, the issues have played out nationally, not just in Western NC. Across the country, several physicians have been "made example of" in high-profile cases in recent years, such as the termination without cause of Dr. Ming Lin by TeamHealth after raising coronavirus concerns. The constant fear that one's livelihood may be at risk combined with a labor monopsony and restrictive covenants leaving little or no other employment options in a geographic area, as well as the potential for blackballing or blacklisting serve as a chilling effect to silence the vast majority of physicians who may have otherwise raised the complaints and concerns of unethical and unsafe practices as well as Medicare overbilling as demonstrated in this complaint.

However, while these issues are national in scope, nowhere at the moment are the effects of corporate healthcare monopolies more salient than in Western North Carolina, where there exist now two ongoing antitrust lawsuits against HCA for alleged antitrust violations.[30] Those antitrust cases, founded on allegations of excessive and monopolistic market power, are partly founded upon the fact that HCA and its vendors like TH as the staffing vendor, are violating CPOM and anti-competitive principles.

One aspect of CPOM is systematic understaffing and chronic under-resourcing where it results in cost savings for private sector owners motivated by profit not patient care. However, Relators here – and ethical doctors everywhere – chose medicine as a calling because they care about the patients, not the profits. Here, the Relators describe how the working doctors and nurses have steadily been leaving their jobs and refusing to work for Mission or Team Health any longer and this has placed ever more stress on the limited number of doctors and nurses remaining. The same understaffing and deteriorated conditions on the ground at the hospitals, are conditions relevant to the antitrust case. That is because one aspect of a monopoly is decreased quality of the product, and decreased output. *See* Complaint in *Davis v. HCA Healthcare*, Buncombe County.[31]

[30] https://www.fiercehealthcare.com/providers/hca-healthcare-faces-another-antitrust-lawsuit-tied-2019-mission-health-merger.
[31] https://sourceonhealthcare.org/litigation/davis-et-al-v-hca-healthcare-and-mission-health-system/

See also Report: Over 220 doctors left Mission Health since its 2019 acquisition by HCA Healthcare, by Dave Muoio, March 29, 2022, Fierce Healthcare, describing:

> Mission Health system has seen an exodus of doctors since being acquired in 2019 by HCA Healthcare, according to a recent report from North Carolina-based nonprofit outlet the Asheville Watchdog.
>
> Citing historical listings on the six-hospital system's Find a Doctor website, the report tallied 223 doctors that were listed in August 2019 but removed by February 2022. These included 33 family medicine physicians, 25 surgeons and 15 pediatricians or pediatric specialists, according to the report.
>
> Per the report, over 100 of the unlisted doctors have since moved out of state. Further, the publication also cited 57 doctors who were still listed on Mission Health's website but were no longer listed as employed or affiliated with the system.[32]

Original reporting by the Asheville Watchdog "How Many Doctors Have Left Mission? HCA Won't Say" quotes HCA spokesperson, Nancy Lindell in response to being sent the names of the doctors no longer employed or affiliated with HCA Mission as responding with "We continue to have approximately the same number of providers on the medical staff to serve the needs of our community." The Watchdog astutely notes that "providers" includes nurse practitioners and physician assistants, leading one to speculate that many of the physicians (MD and DO) have been replaced with non-physician practitioners, lowering the quality and standard of care provided at HCA Mission at the same time that the government is over-billed for services.

In addition to leaving the practice of medicine in Western North Carolina by geographically moving, commuting to other communities, early retirement, or career change, physicians and other healthcare professionals are leaving by suicide. The American Medical Association reports that physicians are at higher risk of suicide and suicidal ideation than the general population, with as many as 500 physicians dying of suicide per year. Related to this, a black physician named Tolu Odufuye, M.D. the chair-elect of the American College of Emergency Physicians Diversity, Equity, and Inclusion Section committed suicide on June 7th, of 2022.

It is known to Dr. Li that Dr. Odufuye believed that she was terminated without cause by both TeamHeath, a defendant, and Envision, an analogous private-equity owned staffing group, which caused her significant stress. Meanwhile, Rebecca "Becky" Parker M.D., a previous president of the ACEP, previous executive of Envision, and current Chief Coding Officer of TeamHealth, both companies from which Dr. Odufuye believed that she was terminated without cause, was named "Champion of Diversity and Inclusion" by ACEP in 2021.

The facts regarding Dr. Odufuye and Dr. Parker further reflect the level of stress occurring in the profession, as well as the current political issues affecting the profession. Numerous physicians are Emergency Medicine physicians. Numerous of those work in Emergency

[32] https://www.fiercehealthcare.com/providers/report-over-220-doctors-left-mission-health-its-2019-acquisition-hca-healthcare

Departments. Many of those EDs are today owned or controlled by HCA and/or by TH. The monopoly claim asserted against HCA in the North Carolina antitrust case is not merely theoretical. A practical effect of the monopsony is that if one is an EM physician who wants to work in an ED in Western NC, the dominant employer is HCA/TH.

TeamHealth was documented by NPR and ProPublica for suing and garnishing the wages of working poor patients in a majority black county,[33] a practice it only discontinued after investigative reporting scrutiny. Specifically, Team Health is known for suing poor patients and garnishing their wages until being exposed by investigative reporters at Propublica.[34] In 2020, Propublica published an expose on Team Health explaining how "rich investors, not doctors profit from marking up ER bills."[35] Relatedly, in 2019, the New York Times exposed the dark money organization "Doctor Patient Unity", which was opposing the implementation of the No Surprises Act, to be funded primarily by Team Health and another private equity owned staffing firm, Emcare/Envision.[36]

Having opposed the No Surprises Act on the one hand, Team Health has ostensibly supported it on the other, belatedly claiming that it is against any surprise billing.[37] Yet in what must come as a surprise to any payors, Team Health has continued to engage in the other kind of "surprise billing" – that is, overbilling for overcharges for Code Traumas, and other items as stated here, and overbilling for higher CPT Codes that should be lower as per the allegations in the *United Healthcare, Celtic* and *LMRMA* cases.[38]

When interviewed by the New York Times in an article covering "surprise billing" in 2016,[39] Yale Economist Zack Cooper noted that "Becky Parker gave [a] quote to the NY Times when we first started studying surprise billing... Unfortunately, she decided not to report she worked for EmCare...the company doing the surprise billing."[40] EmCare was later acquired by Envision and Rebecca Parker is now, as noted, employed as the "Chief Coding Officer" of TeamHealth. TeamHealth is currently accused of up-coding by the insurance company, United

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[33] https://www.npr.org/sections/health-shots/2019/11/27/783449133/a-private-equity-owned-doctors-group-sued-poor-patients-until-it-came-under-scru

[34] https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them.

[35] https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills.

[36] https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html.

[37] Team Health website, stating that Team Health supports a ban on surprise billing. https://www.teamhealth.com/surprise-medical-billing/?r=1

[38] *See Louisiana Municipal Risk Management Association v. Team Health*, No. 3:22-cv-00104 (E.D. Tenn.) (Second amended complaint filed 4/5/22. Case pending.); *Celtic Ins. Co. v. Team Health Holdings, Inc.*, No. 3:20-cv-00523-DCLCHBG (E.D. Tenn.) (see Doc. 1, complaint filed Dec. 10, 2020; Case settled); *United Healthcare Services, Inc. v. Team Health Holdings, Inc.*, No. 3:21-cv-00364, 2022 U.S. Dist. LEXIS 84264, 2022 WL 1481171 (E.D. Tenn. May 10, 2022) (denying motion to dismiss the RICO claim -- $100 million in damages claimed); *United States ex rel. Hernandez, et al. v. TeamHealth Holdings, Inc., et al.*, No. 2:16-cv-00432-JRG (E.D. Tex.) (See 6/14/21 Settlement Agreement, $60M-plus settlement).

[39] https://www.nytimes.com/2016/11/17/upshot/first-comes-the-emergency-then-comes-the-surprise-out-of-network-bill.html

[40] https://twitter.com/zackcooperYale/status/1204937738052612102?s=20&t=L5fp2xr5I74tiBOF6Z9BtA

Healthcare, which claims that the company "purposefully up coded for tens if not hundreds of thousands of medical claims."[41] That matter is in litigation.

(Note: Parker's date of hire with Team Health was April 2021 per Linked In.[42] The Team Health conduct alleged in cases such as the *United Healthcare, Celtic* and *LMRMA* cases dates back to an earlier time period. See generally Team Health Timeline. By contrast, the Relators in the current matter allege current conduct.)

Again, an examination of the corporate structure and facts regarding HCA reflect important issues regarding HCA's CPOM compliance. This is also true with regard to Team Health, the large,[43] private equity-owned medical staffing vendor that HCA uses to staff the Mission system EDs in western North Carolina. In this regard it is important to note that both organizations have previously been sued with regard to False Claims Act matters, and other claims of overbilling. This is relevant because it tends to indicate that engaging in colorably illegal corporate structures and policies is a credible part of Defendants' business model. With regard to Team Health, *see* –

- *United States ex rel. Hernandez v. Team Fin., L.L.C.*, No. 2:16-CV-00432-JRG, 2020 U.S. Dist. LEXIS 26608, *31, 2020 WL 731446 (E.D. Tex. Feb. 13, 2020) (denying motion to dismiss relator's complaint filed under the False Claims Act, 31 U.S.C. § 3729 *et seq.* alleging upcoding and overbilling fraud);

- *Celtic Ins. Co. v. Team Health Holdings, Inc.*, No. 3:20-cv-00523-DCLC-HBG (E.D. Tenn.) (see Doc. 1, complaint filed Dec. 10, 2020 ¶¶ 8-17 alleging *inter alia* systematic upcoding/overbilling);

- *Emergency Care Services of Pennsylvania v. UnitedHealth Group*, No. 5:20-cv-5094 (E.D. Pa.), *see* ECF No. 37 (counterclaim alleging that TeamHealth engaged in upcoding of health insurance claims);

- *United Healthcare Services, Inc. v. Team Health Holdings, Inc.*, No. 3:21-cv-00364 (E.D. Tenn.) (same, primary claim); see May 10, 2022 order denying Team's motion to dismiss United's civil RICO overbilling claim;

- *United States ex rel. Oughatiyan v. IPC the Hospitalist Co., Inc.*, No. 09-C-5418, 2015 U.S. Dist. LEXIS 19066, 2015 WL 718345 (N.D. Ill. Feb. 17, 2015) (denying in part motion to dismiss FCA claim of TeamHealth hospitalist overbilling); and

- *U.S. ex. rel. Mamalakis vs. Anesthetix Management LLC*, 2021 U.S. App. LEXIS 36193, 2021 WL 5818476 (Dec. 8, 2021) (involving TeamHealth anesthesiologist overbilling).

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[41] *United Healthcare Services, Inc. v. Team Health Holdings, Inc.*, No. 3:21-cv-00364 (E.D. Tenn.) (see complaint); https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-teamhealth-upcoded-claims-for-100m-fraud

[42] https://www.linkedin.com/in/rebeccaparkermd/

[43] Ransdell Pierson, Natalie Grover, Blackstone to buy TeamHealth for $6.1 billion, Oct. 31, 2016, Reuters ("TeamHealth Holdings Inc TMH.N on Monday said private equity firm Blackstone Group LP BX.N would buy it for $6.1 billion.").

See Team Health timeline. With regard to HCA, *see, e.g.*, U.S. Department of Justice, Press Release dated June 26, 2003:

> **HCA Inc.** (formerly known as Columbia/HCA and HCA - The Healthcare Company) has agreed to pay the United States **$631 million** in civil penalties and damages arising from **false claims the government alleged it submitted to Medicare and other federal health programs**, the Justice Department announced today.
>
> This settlement marks the conclusion of the most comprehensive health care fraud investigation ever undertaken by the Justice Department, working with the Departments of Health and Human Services and Defense, the Office of Personnel Management and the states. The settlement announced today resolves HCA's civil liability for false claims resulting from a variety of allegedly unlawful practices, including cost report fraud and the payment of kickbacks to physicians.
>
> Previously, on December 14, 2000, HCA subsidiaries pled guilty to substantial criminal conduct and paid more than $840 million in criminal fines, civil restitution and penalties. Combined with today's separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), under which HCA will pay an additional $250 million to resolve overpayment claims arising from certain of its cost reporting practices, the government will have recovered $1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.[44]

See also the numerous antitrust cases involving HCA and related entities.[45]

Based on the information that Dr. Li has reviewed thus far including the fact summaries for Dr. Ramming and Dr. Lalor, and the Complaint, when assessed by Dr. Li in the context of his own knowledge, training, and experience, his preliminary expert opinion is that one or more of the practices by HCA and TH during the pertinent times likely violated the NC prohibitions on CPOM. Further, his preliminary opinion is that overcharging of Medicare and other payers likely occurred as a result of the use of the improper CPOM practices by HCA and TH.

In so stating, it is important to understand that Dr. Li is not criticizing the business models of hospitals in general, or even for-profit hospitals in general, as violating CPOM. Rather, Dr. Li limits his expert opinions in this matter to the precise set of facts set before him, here, involving very specifically the post-transition operation of the Mission hospital system by its current owners HCA, commencing in 2019, and, the practices of TH, commencing in or about April 2020, with regard solely to the Mission Hospital Asheville Emergency Room.

Further, Dr. Li expressly reserves the right to alter, amend or modify his opinions as this matter proceeds based on the intake of new evidence and information herein.

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[44] https://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm.

[45] Most recently see https://orthospinenews.com/2022/06/17/ftc-notches-another-antitrust-win-as-hca-healthcare-steward-health-care-call-off-5-hospital-sale/.

Some hypotheticals -- Subject to those caveats, the available information supports a conclusion that a proximate result of HCA or Team's CPOM violations consists of overcharges to the government. Consider this hypothetical:

- Bob is a physician at HCA Mission Asheville ED. He has to sign off on charts of NPPs but he cannot see the patients, as HCA and TM do not afford him the time, and in his metrics he is instructed to seek to minimize his time per patient. He also lacks the time to truly audit and review the midlevels and determine whether the care, services, labs and scans were medically necessary. Further he knows that even if some of the services were medically unnecessary, it is far too late for him to undo the orders, as they have already been performed. Further, the incremental harm[46] caused to a patient by a medically unnecessary lab or scan is subtle – it is not as if the ordering of an extra metabolic panel will physically injure the patient. So, the doctor simply clicks through and approves all the charts showing work by the non-physician practitioners . It is physically impossible for him to do otherwise; the liability here is solely on the organization. The corporation (HCA or TH) through its billing and coding department shows the physician as being on the chart. They show him as having supervised the non-physician practitioners and approving the care. However, due to CPOM, the non-physician practitioner is over-prescribing, and that over-use of medically unnecessary labs and scans is a) not subject to reversal by the physician who is reviewing the chart quickly and often hours later; and b) actively encouraged, instructed and incentivized intentionally by Defendants.

- Joe Smith, P.A. is an physician assistant /non-physician practitioner at HCA Mission Hospital Asheville's emergency department. P.A. Smith is required to provide emergency department assistance to an incoming patient. Another employee of Team, who is not a physician, has determined that the incoming patient gets a Code Trauma designation.

    - Because of this special Code Trauma designation, and the application of the rule that Code Trauma means extra staff, labs and scans given to that patient, the P.A., Smith, must order certain labs and scans for the patient that in Smith's own professional discretion and view of the situation under his independent medical professional judgment, are not medically necessary and are wasteful.

    - However, even though in Smith's own professional judgment, he would not prescribe the labs or scans to the patient because they are not medically necessary, Smith feels forced to do so because of the rules set by TH as a corporate strategy with a goal of earning revenues and profits through charging for the labs, scans and everything else that is special and extra about a "Code Trauma" patient.

    - In that situation, as a result of the corporate practice of medicine by TH, for an age-65-plus patient who is enrolled in Medicare, there will result an overcharge of Medicare by TH, or by the hospital (HCA), when they send in their bills. This is because they are going to bill extra for the "Code Trauma" patient compared to the regular patient. This patient should not have been a Code Trauma; it was a

[46] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1108766

fraudulent overcharge. Further, P.A. Smith may not have meaningful access to a qualified emergency physician to consult as to whether the case be activated as a "Code Trauma" and the physician may also not have the authority to deactivate the "Code Trauma" and/or may be subject to disciplinary action for not following corporate protocols. The ultimately responsible party is not P.A. Smith, in Dr. Li's opinion, but rather, the corporation, TH in coordination with HCA.

- Joe Smith, M.D. is a residency-trained and board certified emergency medicine physician at HCA Mission Hospital Asheville's emergency department. Dr. Smith believes in his professional discretion that he should be allowed to meet with patients for as long as is medically necessary to ask them questions, have certain tests conducted if needed and review the results, and advise and prescribe for the patient.

    - If he is able to meet with a given patient for five minutes, or ten minutes, then he will not have to order certain labs and scans for the patient. He will be able to rule them out by talking with the patient and taking his time.

    - When Joe Smith, M.D. was a partner in a practice with political equity and transparency in what was billed and collected in his name, Dr. Smith and his partners, also board-certified emergency physicians, could determine the most appropriate balance of staffing levels to allow for an appropriate amount of time per patient.

    - However, when HCA and TH take over the hospital ER system, Dr. Smith finds himself to be only able to meet with many patients for short blocks of time, because the ER is always too crowded and busy and understaffed. The HCA/Team entities further impose de facto quotas by conditioning significant (and for some medical providers and their families, necessary) monetary bonuses on keeping time-per-patient numbers down. Further, by the time a given patient reaches Dr. Smith, Dr. Smith finds that often unnecessary services, supplies, labs and scans have already been both ordered by the non-physician practitioner and performed.

    - In addition, under the pressured circumstances caused by Defendants' CPOM, Dr. Smith finds himself routinely ordering more labs or scans or other likely medically unnecessary services, as defensive medicine. Under the working conditions and circumstances in the Asheville ER, the physician is unable to spend enough time with the patient to rule out various other services and procedures as being medically unnecessary, and so, he allows the patient to receive the wasteful and medically unnecessary services, because the physician was not afforded the reasonable amount of time with the patient necessary to rule those services out and be wholly comfortable not ordering them.

    - In that case, the CPOM conduct by the company is causing overbilling of Medicare for unnecessary labs and scans. Here, what is driving the quotas is the corporate practice of medicine and external profit-making by lay-corporations as a motive,

> compared to patient care as a motive by physicians who have taken an oath. The ownership structure of TeamHealth, by a private equity firm places additional layers of pressure to produce outsized profits in order to service over-leveraged debt levied on the company itself during acquisition that is characteristic of the private equity and "leveraged buyout" industry.

Again, it is important to understand the basic concept of CPOM. According to an opinion by the Attorney General in North Carolina in 1955:

> "A private corporation is prohibited from practicing medicine, and employment by a corporation of a physician or surgeon to treat the ill in order that the corporation may profit therefrom is prohibited by the laws of North Carolina."[47]

It is relevant to review the organizational structure of Team Health. Team Health has an ultimate parent holding company, Team Health Holdings, LLC. Team Health Holdings, LLC directly and indirectly owns various other corporate entities. Further, there are certain important individuals, who have medical licenses, who are officers and directors in the Team Health organization.

There are also small, local medical practices, which may be organized in the corporate form of an LLC or of a Professional Association. Team Health ultimately owns or controls these local medical practice entities, but, it does not call them Team Health. It holds them out as purportedly separate and independent corporate entities each one with its own self-will and independence and each would facially appear to be a haven, as it were, for the individual professional discretion of each of the member physicians in the group.

But these Team Health controlled local practices, are very different from other entities for practices of local physicians. Imagine two practices:

1. **Red Group, LLC** – consisting of five emergency medicine physicians, who co-own the LLC, they each are members of it, they split up its earnings, and they serve as the ER staff physicians at the local hospital. Each physician exercises his or her own independent professional medical judgment in working with patients and has a sphere of professional independence and discretion in which they operate.

2. **Blue Group, LLC** – consisting of another five emergency medicine physicians, who work as 1099 contractors with no employment protections, even if Blue Group controls the schedule of these physicians and even if they have ongoing administrative duties suggestive of W2 employment. Except now a sixth LLC member is a Team Health

[47] https://ncdoj.gov/opinions/medicine-practice-of-medicine-by-corporations/ -- the full document states: "Medicine; Practice of Medicine By Corporations. 9 December 1955. Non-profit and public hospitals may promulgate reasonable rules fixing the standards of those who may practice therein and limiting or fixing reasonable fees for services to be rendered, including medical or surgical, and may arrange with duly licensed physicians and surgeons to provide these services in the hospital. Such services so rendered do not constitute the practice of medicine. A private corporation is prohibited from practicing medicine, and employment by a corporation of a physician or surgeon to treat the ill in order that the corporation may profit therefrom is prohibited by the laws of North Carolina."

> Executive, who rarely if ever works at the hospital, may not even be known to the other five physicians, may not even be working in the state, but who is listed as the president of group. To work at Blue, you must meet the metrics set by the Team Health central corporate office, if you want to get your bonus. Team Health's corporate office will rank your performance against the other ED doctors and show everyone the results. A Team Health non-physician will decide whether or not incoming patients should be Trauma Alerts and you must obey that. All charts must be sent to a Team-controlled coding and billing company called HCFS for the coding and billing. The individual physician is prohibited from reviewing the coding and billing, or disincentivized from doing so through implicit threat of termination without recourse due to misclassification as a 1099 contractor, effectively preventing the physician from serving as a check on Medicare and billing fraud.

Blue Group reflects the corporate practice of medicine.

Dr. Li will testify that in the current business of healthcare environment, the practice of CPOM is not limited to HCA and TH. However, not all medical practice has been usurped by CPOM, either. It is frankly a currently ongoing policy, social, economic, and political battle.

However, the presence of CPOM is especially marked in the 18-county western NC service area within which HCA and TH control a regional monopoly of all healthcare services. Under this situation, in very practical terms, in order to be an ER physician, and reside in the area, a physician may have limited options unless they are willing to work for HCA or TH. That was not the case as recently as back in 2018 – only four years ago.

Unfortunately, though, CPOM is not limited to HCA. As another example of CPOM, Duke-Lifepoint, operating in Western North Carolina and owned in-full by the private equity firm Apollo Global Management, similarly contracts physician staffing services to the Blackstone-owned Team Health. An ongoing lawsuit also alleges that Duke-Lifepoint is attempting to take over an independent group of 1,850 physicians named Private Diagnostic Clinic.[48] It is important to understand that "Duke-Lifepoint" is not part of Duke University nor is it in any way a nonprofit.

In 2012, the 60 Minutes episode "The Cost of Admission" exposed how a joint venture between the now-defunct Health Management Associates ("HMA"), analogous to HCA, and EmCare (now Envision and analogous to Team Health) "relentlessly pressured its doctors to admit more and more patients -- regardless of medical need -- in order to increase revenues," defrauding Medicare of millions. HMA paid over $260 million to resolve false billing and kickback allegations in 2018.[49]

An analogous dynamic now exists between TH and HCA, only with different metrics and mechanisms. According to sources within Mission Health, TH eliminated the requirement for an admitting physician, physician assistant, or nurse practitioner to speak with an inpatient physician prior to admitting a patient from the emergency department, which can promote non medically

[48] https://www.dukechronicle.com/article/2022/02/duke-university-lawsuit-private-diagnostic-clinic-unlawful-practices.
[49] https://www.cbsnews.com/news/hospitals-the-cost-of-admission-03-12-2012/?fbclid=IwAR1eoEUNWbBwVSjjEa7yo_MxVShGJZYdwPZi5Lt7IKbTR_XfRTQYUE6-YFA.

necessary admissions, thereby increasing costs to Medicare and putting patients at unnecessary risks inherent with hospital admissions.

In its investigation of the wrongful termination of emergency physician Ray Brovont at an HCA hospital, NBC News recently exposed how physicians who raise concerns about profit motives harming patients are silenced. It also exposed the mechanism by which private equity owned staffing firms bypass CPOM laws, revealing that one physician, Dr. Gregory Byrne, had been a "paper owner" for up to 300 emergency practices tied to Envision or EmCare. NBC estimates that over 40% of emergency departments are staffed by corporate entities.[50]

While extremely pronounced in Western North Carolina, this is a national issue. An ongoing lawsuit launched by the American Academy of Emergency Medicine - Physician Group in California is alleging the illegal corporate practice of medicine by Envision.[51]

Dr. Li is adequately skilled, experienced, educated and qualified to be an expert in this area. He is a board-certified emergency medicine physician. While he has not published extensive peer-reviewed publications in this area, he has been directly, practically involved in the subject area. He has been published in Medpage Today, cited and interviewed on NPR, NBC News, and in several legal outlets in addition to being an invited speaker for the Federal Trade Commission and Department of Justice. Furthermore, frankly at the present time, many ED physicians, and non-physician practitioners, who have similar or identical opinions regarding the relevant issues, are unable to speak due to the fears of retaliation and blackballing.

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[50] https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975.

[51] https://www.nbcnews.com/health/health-news/doctors-sue-envision-healthcare-say-private-equity-backed-firm-shouldn-rcna9276

For further information, please see:

- Mitchell Louis Judge Li MD, Robert McNamara MD, Natalie Newman MD, Meghan Galer MD, "Aayla Secura" MD, The Reclamation of Emergency Medicine: "Take EM Back," White Paper.
- AAEM Website, https://www.aaem.org/get-involved/sections/yps/rules-of-the-road/corporate-practice.
- EMRA Website, https://www.emra.org/books/advocacy-handbook/corporate-practice/.
- NC Medical Board, https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/corporate-practice-of-medicine.
- Propublica Website, https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills.
- NBC News, Doctor fired from ER warns about effect of for-profit firms on U.S. health care, https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975.
- AAEM Website, AAEM-PG Files Suit Against Envision Healthcare Alleging the Illegal Corporate Practice of Medicine, https://www.aaemphysiciangroup.com/news-and-updates/aaem-pg-files-suit-envision-healthcare-alleging-the-illegal-corporate-practice-of-medicine.
- DHHS, OIG, State Prohibitions on Hospital Employment of Physicians, https://oig.hhs.gov/oei/reports/oei-01-91-00770.pdf.
- Other materials cited in the main body of the summary.

Please note Dr. Li and Relators are entitled to legal whistleblower protection

Please note the legal protections for all whistleblowers. Under state law, *see* N.C.G.S. § 1-613, entitled, "Private action for retaliation action":

> Any employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action under this Article or other efforts to stop one or more violations of G.S. 1-607 shall be entitled to all relief necessary to make the employee, contractor, or agent whole. Such relief shall include reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action may be brought in North Carolina superior court for the relief provided in this section. A civil action under this section may not be brought more than three years after the date when the retaliation occurred.

(2009-554, s. 1; 2018-41, s. 6.). Furthermore, all disclosures herein are subject to FCA federal whistleblower witness protection. See 31 U.S.C. § 3730(h):

> **(h) RELIEF FROM RETALIATORY ACTIONS.—**
>
> **(1) IN GENERAL.—**
>
> Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter.
>
> **(2) RELIEF.—**
>
> Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.
>
> **(3) LIMITATION ON BRINGING CIVIL ACTION.—**

> A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

June 22, 2022.

Citizen Times

NEWS

HCA, Mission hit with 2nd WNC antitrust suit in a year, this one from a Transylvania city

Andrew Jones
Asheville Citizen Times

Published 4:22 p.m. ET June 6, 2022 | Updated 6:05 p.m. ET June 6, 2022

ASHEVILLE - Nashville-based HCA Healthcare is facing its second antitrust lawsuit out of Western North Carolina in less than a year after the city of Brevard filed in district court June 3, claiming the company holds "monopoly power" in some health care service markets and that the "future of health care competition in Western North Carolina ... is at risk."

Brevard's lawsuit follows closely on the heels of an antitrust lawsuit filed by several community members in August 2021, making it the second in a year filed against the for-profit health care behemoth, the largest hospital system in the nation.

It proposes class action for "unlawful restraint of trade and monopolization" and seeks damages and relief through a jury trial.

The history of WNC's antitrust action against HCA Healthcare:

HCA/Mission hit with anti-trust lawsuit, accused of exorbitant prices, declining quality
HCA anti-trust lawsuit filed in Asheville gets extension, new deadlines
HCA: Asheville residents' anti-trust lawsuit is an 'end-run' around Mission hospital sale
AG Stein says he 'will not hesitate to act' if abuses in lawsuit against Mission are true
NC Treasurer files interest in HCA anti-trust suit; plaintiffs reiterate concerns
AG Stein hears WNC leaders on Mission sale fallout, says he's eyeing merger law changes
Mission nurse on HCA fallout during merger hearing: Shocked and horrified

The for-profit HCA Healthcare purchased the Mission Hospital system in 2019, and the lawsuit says it now holds a monopoly market share — 70% or more — in seven counties: Yancey (90.9%), Madison (90%), Buncombe (86.6%), Mitchell (85.4%), Transylvania (78.7%), McDowell (76.4%) and Macon (74.7%).

Transylvania Regional Hospital is in Brevard, the county's seat, and is one of five hospitals in WNC owned by HCA Healthcare and in Mission Health regional system.

“Our lawsuit is being brought at a time when providing affordable health care insurance plans for working families and governmental employees, such as firefighters, police, and teachers, and controlling health care costs have been top priorities for the city of Brevard and members of the class, and the business communities they serve,” Brevard Mayor Maureen Copelof said in a news release disseminated the same day the lawsuit was filed.

She said over the past few years, the community has "repeatedly expressed concerns" about what they say are declining health services, difficulty in obtaining those services and high costs.

"Our attempts to address these concerns directly with HCA have been rebuffed," Copelof said.

HCA and Mission Health spokesperson Nancy Lindell said in a statement that the lawsuit was "beyond disappointing."

She said Copelof recently had requested a meeting with HCA CEO Sam Hazen.

Lindell called that meeting, which included other community leaders, positive and productive.

"We hoped that meeting would be the beginning of a thoughtful and ongoing dialog about healthcare in the city of Brevard and the broader Transylvania County region," Lindell said. "In fact, we provided information requested during the meeting and hosted our first community council meeting just this week."

Lindell noted Copelof in the release did not mention this "apparently long-planned lawsuit, which is frustrating and undermines what we thought were sincere efforts to build open, constructive relationships and lines of communication."

She said the company will now turn its attention to "vigorously defending" the lawsuit.

HCA is already doing that in another case currently waiting judgment in Raleigh's North Carolina Business Court.

There, the antitrust suit brought in August and aimed at HCA's Mission Health flagship operation in Asheville is waiting a decision on whether it can move forward in Buncombe Superior Court.

That case has garnered support from N.C. Attorney General Josh Stein and state treasurer Dale Folwell: both filed amicus briefs in the case, supporting the plaintiffs, Folwell in his capacity as an individual, not as an elected official.

Complaints to the AG: AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story

Demand for safer work conditions: Mission health care workers demand safer working conditions, join national nurses action

Brevard's lawsuit overlaps in many aspects with the Buncombe lawsuit, both noting variety of care options — notable general acute care hospital services — has dwindled since the 2019 purchase and prices have become problematic for the average patient.

The Brevard case, according to the release, is on how the company through monopoly power, is hurting citizens.

"The lawsuit alleges that HCA engaged in a series of predatory tactics designed to impede competition between health care providers," the release stated. "As a result, Brevard, its citizens, and others throughout western North Carolina have paid inflated prices for lower-quality health care."

HCA actions, it went on to state, have also harmed Brevard and its community by:

- Making changes to charity care, impacting some of the most vulnerable members of the community.
- Performing and billing for unnecessary procedures.
- Causing the loss of experienced and highly qualified physicians and other health care providers from the HCA system.
- Reducing the availability of appointments for health care services.

Lindell countered, emphasizing the hospitals' recent successes, specifically those at Transylvania Regional.

"We are proud of our commitment to western North Carolina and the significant investments we have made to serve Brevard and improve patient care," she said.

According to Lindell, those include:

- Missions Health's provision of more than $277 million in charity care and uninsured discounts in 2021.
- More than $14 million in significant infrastructure projects at Transylvania Regional Hospital, renovating three operating rooms, replacing both the MRI and CT and adding a new helipad.
- Provision of access to new specialties there, with five recently added primary care providers in the area and renovated the primary care practices.
- Transylvania Regional's recognition by Healthgrades for Pulmonary Care Excellence and its top 10% national ranking for overall pulmonary services.

"Health care is absolutely critical to the welfare of our community," Copelof told the Citizen Times by phone June 6. "To have good health care we have to have three things. It has to be affordable, it has to be accessible and it has to be of high quality. That's what I'm looking for. That's what I'm trying to ensure that our community has."

Andrew Jones is Buncombe County government and health care reporter for the Asheville Citizen Times, part of the USA TODAY Network. Reach him at @arjonesreports on Facebook and Twitter, 828-226-6203 or arjones@citizentimes.com. Please help support this type of journalism with a subscription to the Citizen Times.

HEALTHCARE

Mission patients endangered by emergency department transfer procedures, nurses say

Hospital defends practices; NCDHHS cites staffing shortage for agency's year-long delay of inquiry

by ANDREW R. JONES and BARBARA DURR
August 24, 2023

Mark Klein has been a nurse at Mission Hospital since 1999 and signed two of the complaint letters that were sent to the North Carolina Department of Health and Human Services. // Watchdog photo by Starr Sariego

*[Editor's note: Since publication of this story, Mission Hospital has changed some transfer emergency department procedures, as detailed **in a Nov. 30 story** by Andrew R. Jones.]*

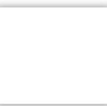
Mission Hospital nurses wrote to the North Carolina Department of Health and Human Services beginning more than a year ago sayi
that staffing issues and communication procedures for transferring patients from the emergency department had jeopardized patient

Privacy - Terms

safety, but the state has yet to send an investigator to the hospital, citing staff shortages.

Asheville Watchdog obtained four complaint letters that were sent to NCDHHS and conducted exclusive interviews with nurses who had expressed concerns that the transfer procedures, known as handoffs, lead to needless delays in care and sometimes endanger patients. In some cases, they said, patients have "disappeared," showing up unexpectedly to other, sometimes incorrect, departments due to lack of communication.

"There is a dangerous practice pattern of bringing unstable patients to medical or stepdown floors or patient decline because of improper transport practices," according to a May 18, 2022, letter authored by the Professional Practice Committee (PPC), 9 unionized nurses at Mission designated to raise nursing concerns with hospital leadership. Step-down units are transitional areas where patients go between the Intensive Care Unit and a general floor.



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NC Division of Health Service Regulation (DHHS)
Complaint Intake and Health Care Personnel Investigations Section
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711

Mark Klein

May 18, 2022

To Whom it May Concern,

As you are probably aware, there have been some changes at Mission Health in Asheville, NC, in recent years. Nurses felt a concerning decline in working conditions and a resultant decrease in patient experiences and outcomes. The nurses unionized and, among other things, elected a committee of peer nurses to make recommendations to the Chief Nursing Officer to improve quality at our hospital. The committee is called the Professional Practice Committee (PPC), and we are the authors of this letter.

The purpose of our complaint is regarding the continuity of nursing care. We acknowledge this has been a challenging time in healthcare. However, one of the practice patterns of concern at Mission Health has been transferring emergency department patients to inpatient rooms. There have been multiple incidents of patient decline because, in many cases, there is no called report. Instead, there is a faxed report, which many nurses never see, and then a "heads up" is signaled, and the patient is brought to the floor. The patient is often brought to the room on the incorrect oxygen delivery device and subsequently declines. At other times patients, patient, are transported to a medical floor where implementation of the orders was not possible before subsequent transfer to a stepdown unit. In one instance, a patient was for help. We will point to a few of these instances below as a jump-off point. The information we have is a medical record number and a brief history.

As you can see, there is a dangerous practice pattern of bringing unstable patients to medical or stepdown floors or patient decline because of improper transport practices. Many of these instances are preventable with a called report to act as a fail-safe. We have requested to end this dangerous process multiple times, including a face-to-

May-18-letter-to-NCDHHS

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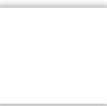
Four nurses said that handoff practices at Mission had resulted in patients requiring urgent transfer to the ICU or being sent to floors where nurses were not equipped to care for them.



Mission has had a committee working on "process improvement related to hand-offs" for at least 15 months, according to emails from the hospital's chief nursing officer to union nurses obtained by *The Watchdog*.

But **Mission's policy** remains unchanged, nurses say.

The policy requires phone calls between nurses for critical care and dialysis patients but not for others.

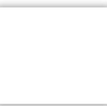
State and federal regulations do not require calls for handoffs, but Mission nurses and a former emergency department doctor said nurse-to-nurse communication ensures a smoother transition and is best for the patient. And the region's three other hospitals – UNC Health Pardee, AdventHealth, and Asheville VA Medical Center – require calls for all handoffs.

The main emergency room entrance at Mission Hospital in Asheville // Watchdog photo by Starr Sariego

Mission allows a range of communication methods, including a review of electronic medical records. The hospital has invested in **iMobile** technology, a communication system that is accessible to all health care providers, Mission Hospital spokeswoman Nancy Lindell said.

"Handoff methods are dependent upon the acuity of the patient and what the caregiver deems as appropriate," Lindell said. "These processes have been reviewed by both The Joint Commission and NCDHHS with no deficiencies found in scheduled or unannounced surveys and no citations given."

The Joint Commission, the nation's largest hospital **accreditation** organization, specifies that hospitals' hand-off procedures should allow "for the opportunity for discussion between the giver and receiver of patient information." The organization **recommends** that staff communicate by telephone or video conference and not solely by electronic or paper methods.



Hannah Drummond, a Mission ED nurse and a National Nurses United union member, said the practice in the emergency department is to call handoff reports for ICU level, pediatric, and trauma patients but not for other patients.

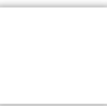
“There’s so much that can be given in nurse-to-nurse handoff that can’t be captured when you’re just reading the chart that it’s important to touch base about,” Drummond said. “It also leaves room for things to fall through the cracks.”

Calls, video conferences recommended

The PPC at Mission has been asking the state health care agency to investigate the hospital’s handoffs for more than a year.

In its May 18, 2022, letter to NCDHHS, the PPC requested an onsite investigation by the agency. The nurses received a response July 13, 2022, from an NCDHHS nurse consultant lead, Deborah S. McCarty.

“We regret that the care provided by this hospital has not been satisfactory,” McCarty wrote. “Your concerns have been reviewed and will be assigned for investigation by a member of our Acute Care Team. You will be contacted when the investigation is complete.”



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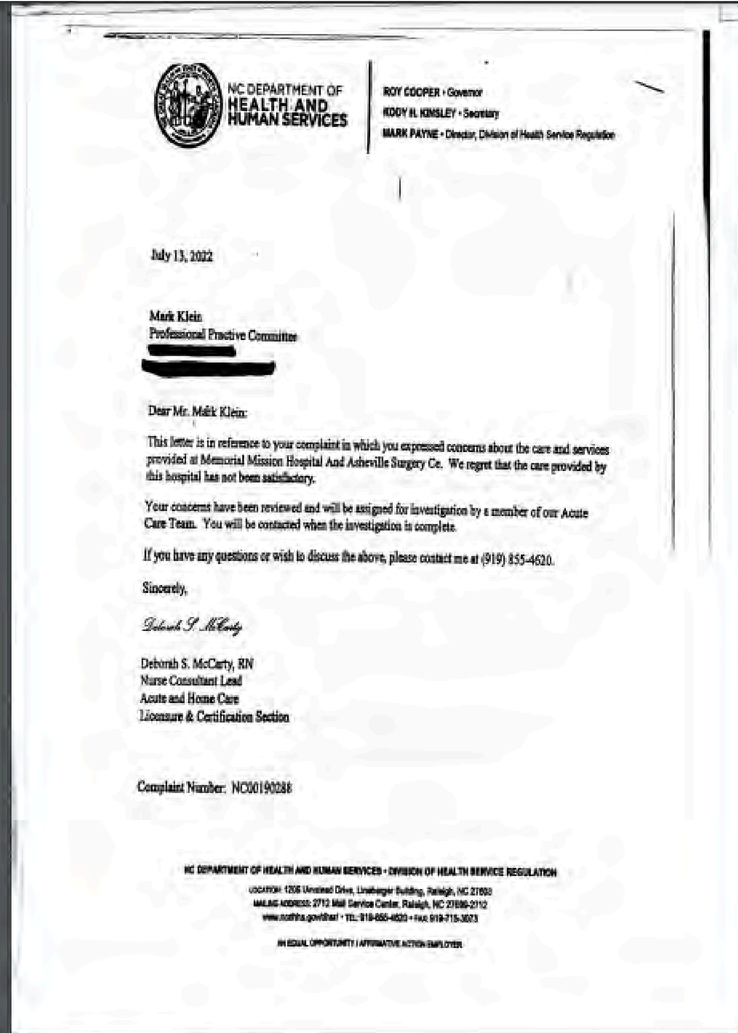

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 13, 2022

Mark Klein
Professional Practice Committee

Dear Mr. Mark Klein:

This letter is in reference to your complaint in which you expressed concerns about the care and services provided at Memorial Mission Hospital And Asheville Surgery Ce. We regret that the care provided by this hospital has not been satisfactory.

Your concerns have been reviewed and will be assigned for investigation by a member of our Acute Care Team. You will be contacted when the investigation is complete.

If you have any questions or wish to discuss the above, please contact me at (919) 855-4620.

Sincerely,

Deborah S. McCarty

Deborah S. McCarty, RN
Nurse Consultant Lead
Acute and Home Care
Licensure & Certification Section

Complaint Number: NC00190288

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
LOCATION: 1205 Umstead Drive, Lineberger Building, Raleigh, NC 27603
MAILING ADDRESS: 2712 Mail Service Center, Raleigh, NC 27699-2712
www.ncdhhs.gov/dhsr • TEL: 919-855-4620 • FAX: 919-715-3073

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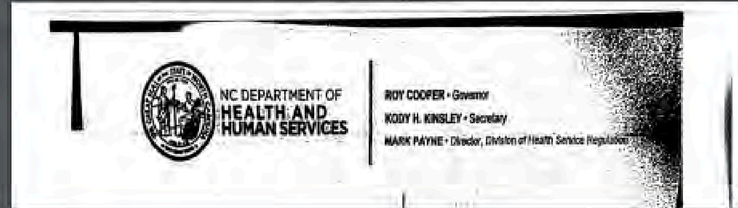

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

McCarty-letters

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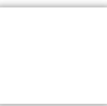
McCarty also responded with identical wording in April 2023 to another nurse complaint letter that raised concerns about cancer care.

No one from the state has visited the hospital to investigate the complaints, nurses say.

“DHSR (Division of Health Service Regulation) lacks sufficient staff to investigate the numerous complaints that it receives as timely as it would like,” NCDHHS spokeswoman Bailey Pennington wrote in an email to *The Watchdog*. “Governor (Roy) Cooper’s Recommended Budget included additional positions that are desperately needed in DHSR to more timely investigate the increasing number of complaints about patient care in acute and psychiatric hospitals, and other healthcare facilities.”



Lindell did not respond to a question from *The Watchdog* about whether Mission or its owner, HCA Healthcare, were aware of nurses' reports that patients were put at risk because of the hospital's communication protocols, as the nurses say.

Lindell said Mission's handoff procedures remain largely the same as they were before HCA bought Mission in 2019.

"HCA Healthcare has gone above the minimum standards and made a substantial investment in our iMobile technology" in 2021, Lindell said, referring to the hospital's electronic communication system. "Once the patient's information is in their electronic health record (EHR), it follows (the patient) and is accessible by any nurse, physician, pharmacy tech or other person who needs that real-time data.

"Because iMobile can be accessed via computers and handheld devices, staff and offsite providers can send this EHR information through secure messaging from anywhere," Lindell said. "iMobile phones also allow staff to call or text to get an answer quickly, allowing for streamlined and efficient communications. This adds up to more time spent caring for patients."

iMobile devices "are used to signal a heads up at best and not utilized to communicate in real time a proper nurse-to-nurse report," said Mark Klein, a nurse who has worked at Mission since 1999, previously in the emergency department and intensive care unit, and since 2014 as a vascular access nurse inserting ports in patients. Klein sits on the PPC, which communicates concerns to Melanie Wetmore, Mission's chief nursing officer.

Handoffs by calls take several minutes, Klein said.

Mission Hospital Chief Nursing Officer Melanie Wetmore // Photo credit: Mission Hospital

"Nurses reporting via phone is inefficient but safe," Klein said. "HCA wants maximum productivity, so they are trying to eliminate the time-tested method of nurse-to-nurse communication. It's unsafe, and we have pointed to many examples where we feel patients were harmed, yet HCA leadership is extremely reticent to change."

Nurses are constantly being reminded of the importance of the time span from patient arrival to time of discharge, known as "throughput," one of the hospital's metrics, Drummond said.

"This word that we hear all the time is 'throughput, throughput, throughput, throughput,'" Drummond said, "So if the patient is holding in the ER for longer, that looks bad on paper."

Complaint letter cites six cases

The nurses' May 18, 2022, complaint letter to NCDHHS describes six emergency department patients who ended up in the wrong area or didn't receive proper care because of handoff communication problems.

"There have been multiple incidents of patient decline because, in many cases, there is no called report," according to the letter. "The patient is often brought to the room on the incorrect oxygen delivery device and subsequently declines. At other times patients … are transported to a medical floor where implementation of the orders was not possible before subsequent transfer to a stepdown unit."

The letter provided to *The Watchdog* redacted patient specifics for privacy purposes, but Klein said they included multiple incidents "where patients were transferred to non-ICU units inappropriately, and the patients required emergent intervention by the Rapid Response Team and transfer to the ICU. Frequently, there was no report or handoff."

Some patients who should have gone to the ICU, for example, went to a general medical floor, two of the nurses said in a joint interview.

Each case "represents a patient we feel was harmed … because of the unsafe profit-centric system in place at HCA," Klein said. None of the letters provided to *The Watchdog* states that patients died.

Mark Klein is a Mission Hospital vascular access nurse who previously worked in the emergency department. // Watchdog photo by Starr Sariego

Kerri Wilson, a cardiac nurse and a member of the PPC, told *The Watchdog* during the interview with Klein, "People are going to die," if the hospital doesn't change its handoff policy.

"Every day patients are transferred from the ER with no report and often to areas that are not the appropriate level of care, which then requires the resources of our rapid response nurse to care for these patients until they can be transferred to ICU," Wilson said.

Claire Siegel, a PPC member who works on a medical surgical unit, said the supervising nurse is often assisting patients and does "not have adequate time to look up incoming patients to ensure they are safe and appropriate to come to our floor. This often results in patients coming to us who are on medications and IV drips that we are not educated or certified to take care of.

"I have never in the last two years received a nurse-to-nurse report from the ED or holding units unless I proactively look up the nurses, call them myself and demand [a] report."

'Many patients disappear'

Another letter to the NCDHHS, dated Nov. 4, 2022, and signed by Klein, described how "many patients 'disappear' from the ER and unexpectedly show up on the floors."

Many patients "disappear" from the ER and unexpectedly show up on the floors. In this situation someone signs there transport form and transport takes the patients to the floor. Nurses are forced to learn about the patient by looking over the chart when they arive. Facts about the history and acute events should be included, and the report should be called. The "orange pod" area of the ER continues to be a disaster. The existing nurses have expressed significant concern to HCA about this ER area. Some nurses have quit or changed jobs, and some travelers never return after working in the orange pod.

An excerpt from a Nov. 4, 2022, letter from the PPC to NCDHHS.

"In this situation someone signs (their) transport form and transport takes the patients to the floor. Nurses are forced to learn about the patient by looking over the chart when they arrive," the letter stated. "Facts about the history and acute events should be included, and the

report should be called."

Drummond, the ED nurse, said that nurses often don't know patients have been moved from the emergency room.

"Sometimes patients are moved to (a) different pod in the (emergency) department, she said, "Or they're going upstairs and I will be in a critical situation or different room and come back and be like 'Where did room seven go?'"

This somtetimes prevents her from getting patient charts up to date and passing medication along, she said.

The Nov. 4 letter also raised concerns about a section of the emergency department for patients with especially acute medical needs, known as the orange pod, that was "grossly under-resourced."

"The 'orange pod' area of the ER continues to be a disaster," the letter said. "The existing nurses have expressed significant concern to HCA about this ER area. Some nurses have quit or changed jobs, and some travelers never return after working in the orange pod."

Klein, Wilson, and Drummond told *The Watchdog* the problems in the orange pod and elsewhere in the ED continue.

"The Orange Pod is designated for those patients who are holding to be admitted," Lindell said. "Sometimes there is a wait for beds to be available and we understand that anytime waiting is involved it can be frustrating for patients, family members, and the teams that care for them. We take concerns brought directly to Mission Hospital leadership very seriously, implementing changes in process and workflow as needed."

The May 18 complaint letter to the state said the nurses had asked Mission administrators to end the "dangerous" transport process and require calls for patient handoffs.

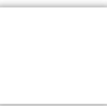
"We have met personally with senior leadership and they will not change this process," the letter said.

PPC's letter to Mission's chief nursing officer

The PPC also sent a letter to Wetmore, dated May 18, 2022, saying it had previously raised concerns to her and others about the risks related to Mission's transferring of patients.

According to the letter, union nurses invited her to a resolution meeting but she did not attend. Klein told *The Watchdog* that she sent two representatives.

"The significant issue about patient safety regards the emergency department … not calling [a handoff] report on all patients," the letter to Wetmore said. "Numerous ED (Emergency Department) patients are being transported to floors and step-down units inappropriately. This process places patients in immediate danger and has placed patients in inappropriate care areas," leading to "multiple patients being transferred" to the ICU.



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May 18th, 2022

Melanie Wetmore RN, DNP, CEN, NE-BC, CPPS
Chief Nursing Officer Mission Health
509 Biltmore Ave.
Asheville, NC 28801

Dr. Wetmore,

We regret that you did not attend our PPC resolution meeting. We raised serious issues requiring immediate attention concerning a direct threat to patient safety. We have yet to receive any response from you in this regard.

We addressed three issues in this meeting. One problem was the universal loathing for the existing CPR recertification process. The other issue is a bottom-up process improvement initiative for ultrasound-guided peripheral IV placement by ICU superusers. The significant issue about patient safety regards the emergency department (ED) not calling report on all patients. Numerous ED patients are being transported to floors and step-down units inappropriately. This process places patients in immediate danger and has placed patients in inappropriate care areas, with multiple patients being transferred to ICU, as enumerated in the meeting. We have documented numerous incidents where patients were likely harmed or experienced significant and avoidable delays in treatment because of this process.

As Registered Nurses, our shared obligation is to ensure safe, competent, and effective nursing care. We have reviewed this issue with our practice consultants, and the NC Nurse Practice Act is clear; identification, development, and updating of standards, policies, and procedures related to the delivery of nursing care; the implementation of the identified standards, policies, and procedures to promote safe and effective nursing care for clients as well planning for and evaluation of the nursing care delivery system fall under your purview. It is your individual responsibility to ensure that there are the human resources to provide this care and policies and procedures to support the safe care of our patients. Both the personnel and the policies in place in the ED are inconsistent with the provision of safe nursing care in our State Nurse Practice Act.

We are preparing to report this issue to multiple regulatory agencies because of your intractable opposition to policies that impede efficiency in HCAs' profit-centric culture. Further, consistent with your obligations under our nurse practice acts, we intend to file a complaint against you with the North Carolina Board of Nursing. We implore you to address this issue with urgency. All ED faxed reports must stop immediately.

Respectfully,

The Professional Practice Committee

[Wetmore-Letter](#)

[**Download**](#)

At the meeting, the PPC showed the two representatives details about the six patients' cases listed in the NCDHHS complaint, Klein said.

The Watchdog obtained an email, written by Wetmore to a PPC nurse after the meeting on May 18 that said Mission had a committee "working on process improvement related to hand-offs. … (A)ny significant process change requires much thought and consideration, which is why we have had a team working on this."

Wetmore said in the email she was told that "our leaders had great dialogue with the committee members during the meeting and have taken the committee's suggestions into consideration."

Also in the May 18 email, Wetmore addressed the six patient cases, Klein said.

"These patient charts were thoroughly reviewed by our quality team," Wetmore said in her email. "As is the case with any patient complaint/grievance, they fall under the heading of patient safety work product and any specific findings would not be shared in this venue. However, what I can share, is that in these cases any system opportunities are addressed as appropriate.

- As far as the hand-off and calling report. I was of the understanding that Daniel brought up that we have (and already had) a committee led by one of our ACNO's working on process improvement related to hand-offs. It was shared with me that the committee members have encouraged staff (as they should) any time an issue comes up to report that through the appropriate systems such as Vigilanz, so this information can be considered by the committee as we always look to improve. As was also brought up in the meeting, any significant process change requires much thought and consideration, which is why we have had a team working on this. In addition, to the discussion we were given a list of patient names. These patient charts were thoroughly reviewed by our quality team. As is the case with any patient complaint/grievance, they fall under the heading of patient safety work product and any specific findings would not be shared in this venue. However, what I can share, is that in these cases any system opportunities are addressed as appropriate.

An excerpt from an email written by Mission Hospital Chief Nursing Officer Melanie Wetmore to a PPC nurse after a meeting on May 18, 2022. Wetmore did not attend the meeting, according to PPC nurses.

"I can assure you that the committee's suggestions have (and are being) considered by leadership."

Lindell did not respond to a request from *The Watchdog* to interview the two representatives. She did say the chief nursing officer can send representatives in her place, according to the union's contract.

Two months later, on July 20, 2022, a PPC nurse emailed Wetmore, saying, "Despite having brought this up multiple times in PPC suggestions and also within the PPC Resolution Process, patients continue to be sent to medical floors without (a) report being called from ED nurses. ED nurses report even being told not to call (a) report."

Wetmore replied in an Aug. 11, 2022, email, writing, "As was shared already, we have a team reviewing handoff process improvement strategies." She requested the nurses to alert their supervisors of issues with "following the procedures that are in place."

A year later, on Aug. 9, 2023, Wetmore sent an email to a PPC nurse, saying "we have a joint team of ER and inpatient leaders who continually evaluate this process and are looking at process improvements for handoff communication between caregivers. In the meantime, we will continue to follow the guidelines set forth by the Joint Commission."

When asked by *The Watchdog* if Wetmore would comment for this story, Lindell issued the following statement:

"Mission Hospital's Chief Nursing Officer regularly responds to communications from staff, including concerns from the nursing union. In addition, she regularly attends staff meetings and meets with all nursing areas in the hospital on a rotating basis."

Two doctors' perspectives

Allen Lalor, an emergency department doctor who retired last year after 27 years at Mission, said that nurses are the experts on these type of handoffs, but based on his experience, "there's nothing quite like having a conversation with people so they can get the subtle nuances of the other parts of conversation, and it gives the accepting nurse a chance to ask questions and get a sense of how sick this person is.

"I liken it to what happens in the military, when people change guard duty — I'm going off duty, you are now responsible for the people you are guarding and watching. So much of medicine is based on experience and what you've seen before and your sort of inside knowledge and insight about how sick the patient in front of you looks. To communicate that safely to the person, to the nurse upstairs, I think is invaluable."

Dr. Amanda Green, chief medical officer at Paris Regional Health in Paris, Texas, wrote a July 5 **article** in *The Hospitalist* magazine about emergency department handoffs and spoke to *The Watchdog*.

Amanda Green, chief medical officer at Paris Regional Health in Paris, Texas // Photo courtesy of Amanda Green

"That discussion is expected because there's just a lot that you can't express in a medical record," said Green, who is a liaison between administration and medical staff and who works on projects to improve patient safety and physician workflow. "Most hospitals I know, there has to be a handoff phone conversation from nurse to nurse and clinician to clinician whenever there's a transition of care.

"I think especially as we've gotten more electronic, we've gotten more texting, people don't talk to each other as much. It takes an effort. There's a little bit of an inertia you have to overcome to have that conversation, but it's always positive. It's always in the patient's best interest."

Direct communication can even create more camaraderie across the hospital, she added, noting that calls during handoffs help prevent burnout.

Data cited by the Joint Commission as well as **recent academic research** shows that communication failures, including those involving patient handoffs, have led to **numerous** medical errors and thousands of malpractice claims in the past two decades.

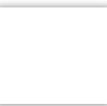
A procedure that comes with risks

Communication involving handoffs is the nurses' primary concern in the complaint letters. Handoffs are risky regardless of how they are managed, **research shows**.

"While it sounds simple, a high-quality hand-off is complex," the Joint Commission stated in a **2017 issue** of its *Sentinel Event Alert* publication, a statement that is still applicable today, according to a spokesperson. "Failed hand-offs are a longstanding, common problem in health care."

The Joint Commission's hospital standards for accreditation require only that, "The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information."

But the Joint Commission has provided **additional guidance** for hospitals with eight tips for "high-quality hand-offs," recommendations issued in 2018 that a TJC spokesperson confirmed were current.



“Don’t rely solely on electronic or paper communications to hand-off the patient,” the third tip reads. “If face-to-face communication is not possible, communicate by telephone or video conference. This allows the time and opportunity to ask questions.”

A portion of Joint Commission tips for handoffs says patient transfer communication should happen through a call, not just through electronic or paper records. // Credit: The Joint Commission

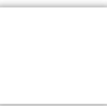
The state does not specify how hospitals should conduct handoffs, said Kelly Haight Connor, an NCDHHS spokeswoman. “Hand off is a standard seen in health care facilities to promote follow through and a continuity of care among staff. There is no mandated statute or regulation to define the process,” she said. “Each facility is responsible for defining the practice and protocol.”

A section of the North Carolina Administrative Code mandating the responsibilities of registered nurses requires communication by them to be “direct,” to “evaluate the responses to information reported” and to “determine whether further communication is indicated.” Klein contends the optimal handoff is a two-way call or face-to-face conversation between care providers.

Lindell said Mission’s handoff policy is evaluated “on an ongoing basis… [and] meets the elements outlined by The Joint Commission, allowing for electronic transmission, in-person exchange and/or telephone communications between caregivers with the receiver’s ability to further ask questions at any time.”

Other hospitals in North Carolina require calls for handoffs.

“At UNC Health Pardee a handoff report via a phone call from the nurse is required whenever a patient is transitioned to a new caregiver or care unit regardless if it is an internal or external location,” said Marilee Arnold, Hendersonville-based Pardee’s interim chief nursing officer.



AdventHealth Hendersonville's emergency department team "is required to call (a) report when transferring an ER patient to an inpatient unit," said spokeswoman Victoria Dunkle.

The Western North Carolina VA Health Care System requires "a nurse-to-nurse handoff," said the system's spokesman Vance Janes. "The ED nurse will call and give the report over the phone to the receiving nurse or, if medically necessary, the ED nurse caring for the veteran will transport the veteran to the next level of care and give a bedside report to the receiving nurse."

A spokesperson for Novant Health's Forsyth Medical Center in Winston-Salem said "Our teams rely on telephone and face-to-face handoffs for emergency department transfers."

Drummond, the ED nurse and union member, said traveler nurses who spend time at Mission are surprised by its handoff policy.

"When we have travelers come in…they're like, 'We don't call (a) report at this hospital?'" she said.

Concerns about nursing staffing

The complaint letters mostly focus on handoffs but say that short-staffing on several nurse floors is also endangering patient safety.

Wilson said that "pretty much every shift" she files a formal complaint known as an **Assignment Despite Objection**, developed by the nurses' union to document unsafe assignments that they believe put patients at risk.

"My unit is pretty much always short-staffed," Wilson said. "Anytime I have more than four patients, which is **our recommended nurse-to-patient ratio** for our level of care, I fill one out and I would say several units in the hospital every day fill those out."

Lindell said hospitals across the country are facing nursing shortages, as *The Watchdog* **recently reported.**

"Healthcare staffing challenges continue across the country," Lindell said. "We have made positive strides in 2023 to fill open positions, having added almost 200 experienced RNs and 100 new graduate RNs to our staff so far this year."

She said Mission Health continues to heavily recruit and fund caregiver education in Western North Carolina.

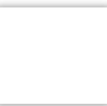
Investigative staff shortages

NCDHHS investigations are conducted by the Division of Health Service Regulation (DHSR) on behalf of the U.S. Centers for Medicare and Medicaid Services (CMS). The division reviews complaints with CMS, then prioritizes them for investigation.

The DHSR suffers from a staffing shortage, said Pennington, the NCDHHS spokeswoman. The department hopes the next state budget will include funds allowing it to add positions, she said.

"Without additional investigators and more funding to increase the pay for those already employed, DHSR's ability to respond to complaints will worsen and the backlog of complaint investigations will continue to grow," Pennington said.

NCDHHS currently has a 26% overall vacancy rate, Pennington said.



"One of every four positions is vacant — a statistic that's even higher in our state-run facilities — and the Department's annual turnover rate (number of staff who leave their jobs each year) is approximately 34%," she said.

A CMS spokesperson said the agency "has communicated with NCDHHS about its delays and are providing technical assistance and collaboration for NC State to overcome obstacles that may cause delays in CMS's complaint investigations within the levers CMS has available to do so."

An area lawmaker says she thinks the NCDHHS staffing is "the main problem."

Sen. Julie Mayfield // Credit: North Carolina General Assembly

"Pay remains low, and the agency is competing with hospitals and others for the kinds of people needed to do these investigations," said Sen. Julie Mayfield, D-Buncombe. "The state simply cannot compete until we raise wages to market or close to market rates."

She encouraged nurses and the public to continue sending complaints to DHHS, "Maybe someone will hit on a hot button issue that demands a response or maybe we will eventually be the squeaky wheel that gets the grease," Mayfield said.

Mission nurses remain frustrated.

"If it were really about a lack of investigators, why are we still having people come to investigate a patient or family member complaint … within a couple of weeks even of it happening?" said Wilson, the cardiac nurse.

Drummond, the ED nurse, said the absence of mandated calls for all handoffs ultimately threatens both patients and nurses.

"If something bad happens to my patient, number one, that bothers me so much as a nurse. I take it personally when something preventable happens to my patient, and I think we all do," she said. "Secondly, that's on my nursing license. If I've sent a patient who becomes more unstable up to the medical surgical floor and I didn't get (a) handoff report and something happens, theoretically that comes back on me."

Klein said he wants investigators to talk to Mission nurses.

"I would like them to go up on the floor and essentially conduct a survey of the nurses and see if they ever get [any handoff] report because I asked the nurses upstairs and they tell me they never [do]. … I think it's just dangerous."

Reporter Sally Kestin contributed to this story.

Asheville Watchdog gratefully acknowledges the assistance of Lawyers for Reporters, a joint project of the Cyrus R. Vance Center for International Justice and the Press Freedom Defense Fund.

Asheville Watchdog is a nonprofit news team producing stories that matter to Asheville and Buncombe County. Andrew R. Jones is a Watchdog investigative reporter. Email arjones@avlwatchdog.org. Barbara Durr is a former correspondent for The Financial Times of London. Contact her at bdurr@avlwatchdog.org. To show your support for this vital public service go to ***avlwatchdog.org/donate.***

Peggy
August 24, 2023 at 8:21 am

Oh well. Everything else in Asheville sucks and no one will do anything about it so the hospital might as well suck too. Unless you like sub par quality of life, move. 😔

Gary Egerer
August 24, 2023 at 9:04 am

We are talking about a phone call, for goodness sakes. Please HCA, you just made 15 billion profit, let's make the process a little safer. This could save someone's life

Barton Evans
August 24, 2023 at 9:06 am

Excellent reportage. Please keep the pressure up on HCA, because based on other communities' experiences, this is the only way to keep them even marginally accountable.

Silverwolf
August 24, 2023 at 10:58 am

From all the articles that have been published recently about the incompetence that apparently abounds at Mission Hospital, one has to wonder why this hospital has not been closed down by the appropriate licensing agencies. Why are they being allowed to operate when they are clearly putting patient lives in jeopardy? Someone at Mission or its ownership apparently has some real pull with those agencies that keeps the incompetence at Mission operating.

Wayne Stiles
August 24, 2023 at 11:10 am

Let's see now, who to believe? Either the nurses on the floor having intimate care and responsibility for patient safety or the HCA administrator responsible for maintaining or increasing profit in order to pay the costs of purchasing Mission? Quite a conundrum-NOT.

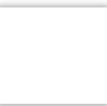
John Mycroft
August 24, 2023 at 11:50 am

A brilliant report about a disgusting state of affairs. Remind me again why we are so opposed to universal healthcare.

Fedup
August 24, 2023 at 12:50 pm

"She encouraged nurses and the public to continue sending complaints to DHHS, "Maybe someone will hit on a hot button issue that demands a response or maybe we will eventually be the squeaky wheel that gets the grease," Mayfield said. This is repulsive. Our elected state senator and this is the best she can come up with? The hot button issue is that people's lives are in danger. What kind of lame response is this? What ever happened to that forced hospice issue NBC reported on? The cancer center? Those nifty letters the AG wrote haven't done much have they? Mission is a dumpster fire that keeps burning. The state has no investigators and HCA sits up there like the Cheshire Cat knowing there will never be any meaningful oversight. Sick.

RG
August 24, 2023 at 1:56 pm



I also get tired of this deflective response from elected officials. We're constantly having to attend meetings and send letters about everything that endangers our lives.

Fedup

August 24, 2023 at 2:28 pm

Right on, and our elected officials, local and state rarely miss an opportunity to attend one of HCA's spectacular ribbon cutting or ground breaking ceremonies, complete with shovels or a big pair of scissors in hand. But when people's lives are at stake at, she tells us to file a complaint with the state, who has no staff to investigate. Make it make sense.

Peggy

September 1, 2023 at 11:50 am

Agreed. We are basically left to fend for ourselves in Asheville. That goes for both police/crime and medical care/hospitals. The gaggle called city council and the elected senator are too wrapped up in their personal agendas to instigate change the residents need.

Bingo

August 24, 2023 at 1:33 pm

That explains why when I called NCDHHS a couple weeks ago to follow up on a previous Mission complaint, they told me there was nothing they could do, and advised me to get a lawyer or contact the Governor. Wow. We are on our own indeed. Thanks to the Watchdog for their tenacious reporting. We should be making our tax payments to the Watchdog not to our useless government.

Peggy

September 1, 2023 at 11:50 am

We are 100% on our own.

Robert McGee

August 24, 2023 at 1:58 pm

At first I thought the headline said 'Missing patients…' I think that would make another intriguing story.

PokerFace

August 24, 2023 at 2:14 pm

The article does mention patients who have disappeared. The best bet is to avoid Mission hospital if you can. You'll have better odds playing Russian roulette. There has already been reporting on what a disaster the ER is. This is just more confirmation.
The feds should step in. No telling how many unnecessary deaths have occurred there. Someone needs to look at their books, both sets.

Emmie

August 24, 2023 at 8:06 pm

Let's donate and support this type of investigative reporting. Holy smokes this is a scary article.

Bollocks

August 25, 2023 at 9:05 am

This is not a hospital, it's a grifting enterprise disguised as a hospital, subsidized by federal funding of medicare and medicaid. But that whole independent monitoring sham cannot address quality of care issues, only "services." As long as they provide "services" they're untouchable apparently, even if those services decline to the point where patient lives are in danger.

Dr. Maestro Bonez

August 25, 2023 at 1:45 pm

This is exactly the kind of tenacious reporting Asheville needs. Thank you for what you do, Watchdog. I'll continue supporting y'all as long as you keep this up!

Bollocks

August 25, 2023 at 2:03 pm

This is a very disturbing article. Imagine being a patient and having your name on a list that was sent to the state stating that your life was in danger. I wonder if the patients or families were told that the ball was dropped in their care. I guess not because its considered "work product" which is another hospital term for cover up.

Paula Ho

August 25, 2023 at 3:41 pm

Unfortunately, one of the best safeguards against medical errors is to have a well-informed personal advocate and to ALWAYS have a friend or family AT BEDSIDE to assist in caring for the patient. Basic notes regarding tests and treatments should be written in a journal for reference amongst them. Pertinent and succinct questions demand a reasonable response; major alterations in the Plan of Care should be freely shared by staff, but if not, requested and answered in a timely fashion. In this situation, when transport arrives the destination would be clarified. Once arriving to the unit that advocte is the fastest source of basic information (because an over-assigned floor nurse will have none).

Libby Fisher

August 27, 2023 at 2:58 pm

Thanks for this in-depth reporting. Based on my own experience, I should probably report my issue with Mission, but I read one comment that said they reported, and on follow up NCDHSS said nothing could be done.
I was transferred from Pardee in HVL to the trauma center due to two fractured vertebrae and a fractured sternum. The difference in the demeanor of staff between the two ER's was dramatic. Mission was packed, gurneys lining the halls, nurses seemed to be bickering about next steps. I wasn't supposed to get out of bed, so I asked the nurse about a catheter. She provided an external catheter with little instruction on how it worked. I was then moved to another area of the hospital, not a regular room but not sure where. The nurse that moved me acted like he was doing so on his own to get me a better bed. There were words with another nurse, just more discord among staff. By this time it was 1:00 a.m. Suffice it to say, the catheter didn't do its job so I'm lying in a wet bed and cannot reach the call button. I pulled off every monitor I had on, thinking a blank screen at the nurses' station might bring staff in. I waited an hour and a half before I heard voices in the hall and yelled for the nurse. The nurse apologized and got me and the bed cleaned up, but I still wonder why no one was monitoring the BP/pulse/O2 on the nurse's end. I listened to the warning alarm go off for 90 minutes. Good thing I didn't have an issue with my vitals.

cl

August 28, 2023 at 6:18 pm

This situation is truly alarming! It is not only clearly dangerous, but it is also contributing to nurse burnout.

I was a nurse at Mission back in the days of verbal reports during patient transfers. I can think of at least one patient who might had died if the transferring nurse had not been able to give me a verbal report. The patient had been reporting serious symptoms to her MD for days before she was finally seen and admitted. That information might well have not been available in her chart since it reflected poorly on her care provider. It did set off my spidey sense that she might be much more unstable than her triage vital signs indicated. Though another nurse checked her in during shift change report and still got vital signs within normal limits, I ignored my other urgent duties and rushed in a few minutes later. She was already in full blown septic shock! Fortunately, quick action was able to bring her back.

Forcing nurses to interact with mobile devices to get basic information about newly admitted patients instead of allowing them to speak with the nurse who has gotten to know them disrespects all nurses. It treats them like cogs in a wheel. They simply produce "work product" in isolation from their colleagues. That is definitely a recipe for burnout! Nurses go into nursing to interact with people, not machines.

The "suits" in HCA management may believe that verbal communication during handoffs is inefficient. As a former nurse, I disagree. I could get my questions answered so much more quickly than pouring through a chart or reinterviewing the patient. I simply cannot imagine trying to function in a hospital that did not require verbal reports. This experienced nurse would certainly take her education and experience and spidey sense elsewhere. HCA will have to staff Mission with new grads and expensive travelers. It doesn't seem like a cost effective of efficient way to run a hospital.

Ana Prendergast

August 29, 2023 at 11:09 pm

What this story doesn't even broad is their policy that sees them regularly discharging adult and geriatric psychiatric patients – including those under IVC orders – back into the community, within hours of arrival, with no plan for continuing care being offered and no discharge plan. These pervasive HCA issues are alarming across the board, but someone should be asking questions about how they get away with regular unsafe psych discharges.

Peggy

September 1, 2023 at 11:55 am

If you have the means to get out of Asheville, do it now. Things continue to deteriorate: water, roads, hospital, police/crime, short term rentals, homelessness, drug addicts, public schools, cost of living, public transportation. Anyone see any improvement in any of these things?

AJ Elle

September 4, 2023 at 4:37 pm

Unfortunately, transporting patients out of the ER without giving report to the receiving unit/RN is becoming increasingly common in hospitals across the country. RN's are told they are getting an admit wether they are able to safely care for an additional patient or not. If the nurse is busy caring for multiple complex patients, they may not have even have had time to learn they are getting another patient. Often the patient arrive and has been placed in a room with no staff being aware or able to attend to them. It's all about "throughput" and moving patients out of the ER-basically treating healthcare like a factory and patients like they are widgets.

We need national safe staffing laws, breaks laws, and anti-violence against healthcare workers to fix these insidious problems.

#safestaffingsaveslives
#patientsbeforeprofits
#patientratiosnow

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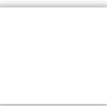

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Nurses rally outside Mission to again push for safe staffing on Nationa

by Stephanie Santostasi
Thu, January 26th 2023 at 12:27 PM

JAN. 26, 2023 - Nurses rallied outside Mission Hospital Thursday morning, Jan. 26, along with thousands of other nurses across the nation doin Action, spearheaded by the organization National Nurses United. The aim in Asheville was to, again, call for safe staffing levels, as the nurses r to be understaffed is putting both patients and staff in danger. (Photo credit: WLOS staff)

TOPICS: ASHEVILLE ASHEVILLE,NORTH CAROLINA,UNITED STATES HEALTH MEDICAL PHARMA MISSION HEALTH LESTER

for a National Day of Action.

That included some nurses at Mission Hospital in Asheville. They continue to push for safe sta

This rally at Mission is the first one since the hospital made national headlines earlier this mo

Nurses News 13 spoke with Thursday said, despite that national attention, nothing has chang

MISSION HOSPITAL NURSES RALLY TO HIGHLIGHT CONCERNS ABOUT WORKPLACE VIOLI

Nurses rally outside Mission to again push for safe staffing on National Day of Action

“The whole country saw firsthand just what hospital management thinks of us on the Nightly said Shelby Runkles, a cardiovascular ICU RN at Mission. “The fact that management has no d documentation of the staffing crisis at our facility is exactly why we need to take action like th paperwork, we’ll make sure they see us outside.”

“We continue to be ignored by management,” said Kerri Wilson, a registered nurse at Mission

Wilson and others said they want to end their profession’s staffing crisis by making HCA provi to care for patients.

MISSION HOSPITAL NURSES RALLY FOR PATIENT SAFETY; CITE CONCERNS OF CHRONIC S

She said it continues to be an issue — especially in the emergency department.

and so there are days where there's well over 100 patients just waiting," Wilson added.

MISSION HEALTH NURSES JOIN IN NATIONWIDE ACTION AGAINST REPORTED UNSAFE W

A Mission spokesperson responded to those claims made by the nurses in the following state
Thursday morning:

"While the NNU has chosen to attack hospitals across the country, our focus is on providing the be patients. This labor union has a history of this type of activity, which includes using misleading info to garner media coverage. The reality is, there is a national nursing shortage, exacerbated by a pa patient surges. Our Chief Nursing Officer and many others continue to discuss in countless convers are doing everything possible to hire more nurses and other clinical support roles.

We are proud of the high-quality care we provide and continue to recruit new nurses with 19 recru the next few months. Our $20 million wage increase in September 2022 has resulted in more than the Mission Health team. We have received many recent recognitions for our quality and safety fro healthcare organizations including our recent Leapfrog Grade A and HealthGrades America's 50 B

We value all members of our care teams and neither this, nor any other labor union activity, will c commitment to quality, safe patient care and services to our patients and this community."

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HEALTH

Asheville nurses rally for change at Mission Hospital ahead of union contract renegotiation

Nurses union endorses Josh Stein for governor as members rally, calling for higher nurse-to-patient ratios, security measures and better pay.

by *Jane Winik Sartwell* • *June 6, 2024*

Nurses at Mission Hospital rally on June 5, 2024, in Asheville ahead of their union contract renegotiation. Provided

Nearly 100 Asheville nurses rallied outside **Mission Hospital** on Wednesday morning, less than a month before the renegotiation of their contract with HCA-owned **Mission Health**.

With the backing of their **union**, the National Nurses Organizing Committee (**NNOC**), nurses at the hospital are seeking to draw attention to what they see as severe problems with their expiring 2020 contract.

The rally comes at a time when HCA, owner of Mission Hospital parent company Mission Health, faces increased pressure over its oversight of health facilities in Western North Carolina, including **federal regulatory actions** and **lawsuits from**

local governments and the state Department of Justice, plus the recent state selection of a competing company to launch a new hospital in the Asheville suburb of **Weaverville**.

Elle Kruta, a case manager in Mission Health's Women's and Children's ward, told **Carolina Public Press** that the nurses' current contract falls short in three major areas.

The first of these is nurse-to-patient ratios, or "safe staffing" protocols, in place to guarantee both the standard of care for patients and the well-being of their providers.

In the intensive care unit (ICU), for example, nurses are asking for no more than two patients to every nurse. This is the law in ICUs in California and New York, though there is currently no national standard. National Nurses United, of which NNOC is a part, is a co-sponsor of a bill currently before Congress to enact a federal 1:2 ratio.

The second major issue with the contract relates to what nurses describe as increasing instances of workplace violence they face in Asheville. According to a spokesperson from NNOC, this violence is generally perpetrated by patients and their families.

Rather than criminalize patient behavior, nurses are asking HCA to include preventative policies in the contract itself. Nurses are asking the hospitals to promise to make plans to address nurse safety, from making sure weapons stay out of the hospital to reviewing unit layout plans to identify and mitigate isolated, high-risk areas.

"We had nurses that had been punched, that had been bit, we had nurses that were strangled, pushed up against a wall, pushed into an elevator," Kruta said. "We need a safe place to work. And we need a safe place for patients to come to. We don't want to keep hearing that, 'Oh, it's just part of your job.'"

Reducing workplace violence ultimately circles back to the staffing situation, the NNOC spokesperson said. Patients who are already in an emotionally fragile state may react impulsively and erratically when faced with the frustration of not being able to find a nurse.

What the union identifies as the the obvious solution — hiring more nurses — is not one that appeals to budget-conscious hospital management.

The third area of concern is salary.

"We are asking for a fair cost-of-living wage that would allow nurses to be able to live in Asheville," instead of outside city limits, Kruta said.

Mission's current offer is a 3% salary increase over three years. "None of that is keeping up with (Asheville's) cost of living," Kruta said.

"Nurses are an important part of our care team and we remain committed to reaching a contract agreement that is fair and equitable and allows us to continue to provide the excellent care our community deserves," said **Nancy Lindell**, Director of HCA's North Carolina Public Relations.

But HCA had less sympathy for the political dimension of Wednesday's rally: the union announced their official endorsement of Democratic gubernatorial candidate, state Attorney General **Josh Stein**, who is currently suing HCA for

allegedly breaching stipulations of its Mission Health purchase agreement.

“It is disappointing that gubernatorial candidate Stein would use the union rally as a campaign stop,” Lindell said. Stein was in attendance at the rally Wednesday morning, where Mission RNs **Hannah Drummond** and **Mark Klein** made speeches.

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Citizen Times

LOCAL

Historic move: new group says HCA must sell Mission, Western NC's main health care system

Joel Burgess
Asheville Citizen Times

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ASHEVILLE - In a historic move, elected officials, doctors and others have formed a group with the goal of compelling the sale of Mission Health by HCA Healthcare, a for-profit company and the nation's largest health care entity whose $1.9 billion purchase of the nonprofit Mission led to a serious decline in health care for Western North Carolina, said the group, Reclaim Healthcare WNC.

“We are giving voice to the people of this region who are disappointed and angry at the degradation in the quality of care being provided in the Mission system, and particularly at Mission Hospital,” N.C. state Sen. Julie Mayfield, a founder of the coalition, said in a statement released July 24. “We are also a voice for the physicians, nurses, and staff who work at or with Mission who are not able to speak out due to the culture of fear and retaliation that HCA has created.”

The Citizen Times reached out to Mission/HCA.

Since the 2019 purchase, HCA's "systematic playbook-driven cuts" to staffing, services and resources along with a "rigid corporate culture" in search of profits undermined public trust and diminished a system that once provided best-in-class medical care, said a GoFundMe site that was online prior to the announcement.

A GoFundMe page as raised $14,000 and along with $40,000 in direct donations, the group has raised some $54,000 for the effort, according to Reclaim leadership.

Among the organizers are:

- Dr. Clay Ballantine
- Brevard Mayor Maureen Copelof
- Coalition of Asheville Neighborhoods President Rick Freeman
- Nurse Nansi Gregor-Holt
- The Rev. Missy Harris
- Victoria Hicks, Health Equity Coalition member
- Dr. Scott Joslin
- Dr. Bruce Kelly
- Dr. Robert Kline
- Dr. Allen Lalor
- Geri Legeay
- Steve Legeay
- N.C. state Sen. Julie Mayfield
- Dr. Mike Messino

John Nicolay
Nurse and patient advocate Karen Sanders
Former Western Carolina Medical Society Director Miriam Schwarz
Highlands Mayor Patrick Taylor

Move to compel sale 'unprecedented'

The goals of the group are to replace HCA with a nonprofit owner "committed to meeting the healthcare needs of the people of WNC," as well as "holding HCA accountable for their harmful culture and practices," and restoring best in class care for the system, leaders said.

To achieve them, the coalition plans to use public advocacy, engagement with state and federal regulators and public pressure and legislative pressure, they said.

Mayfield told the Citizen Times the move to push out a hospital owner in such a way appeared to be unique.

"I can tell you pretty definitively, because we've asked and looked all around the country, that there is no community that is organizing in the way that we are against HCA," said the Democratic state legislator from Asheville.

Mark Hall, professor of law and public health at Wake Forest University, said the only similar example he knew of was in the late 1980s and early 1990s in Denver, Colorado. The nonprofit Presbyterian St. Luke's had been sold to the for-profit AMI company. A group then arranged to buy back the hospital, though the situation was different in that AMI had initiated the sale because of financial difficulties, Hall said. In contrast Mission is HCA's second most profitable hospital with $1.3 billion in net patient revenue, according to Definitive Healthcare.

"This strikes me as fairly unprecedented," the professor said of Reclaim's effort.

Copelof, the Brevard mayor, emphasized the issue goes beyond the main hospital in Asheville, saying it is a regional problem.

“Our local hospital in Transylvania County has also been negatively impacted by HCA’s ownership, and the ability of our residents to receive care locally has been greatly diminished," she said.

More: NC Attorney General says HCA lawsuit counterclaims 'flatly contradicted' by patients

Criticism of HCA's ownership started shortly after the 2019 purchase. By 2020, nurses had unionized and now say they might strike without increased staffing and pay. Local governments, residents and former workers have sued over claims of anti-trust activities and illegally withheld salaries.

In one of the ongoing suits, N.C. Attorney General Josh Stein accused the company of failing to maintain levels of care in the ER and cancer treatment as promised during the purchase.

Federal regulators, meanwhile, sanctioned HCA for nine cases of "Immediate Jeopardy," to patient safety, including four deaths. That put at risk the hospital's access to Medicare and Medicaid payments for patients relying on those forms of government health care. HCA came back into compliance June 11.

Kelly, a retired family physician who spent 30 years at Mission, said in the statement, “HCA’s profit-driven culture and management has led to the departure of hundreds of physicians, nurses, and other staff," leading to problems such as those noted by the Immediate Jeopardy cases.

Messino, a retired oncologist, told the Citizen Times the practice he founded, Messino Cancer Center, ended its relationship with Mission and expanded the practice after many of the hospital's cancer care staff left.

"They were the support people you need to take care of leukemia patients," he said. "And so the group decided it was not safe to take care of leukemia patients there anymore."

Messino said he believed what Reclaim was doing was part of a larger movement away from corporate ownership.

"I think people are looking at all the money that goes to shareholders and hospital administrators and realize it could be used to take care of people. I think this is the beginning of a movement to change how health care is paid for," he said.

More: New hospital, more beds for Asheville area, Buncombe? NC officials seek public comment

How a quick and unexamined legislative move changed the course of Western NC's health care

Joel Burgess has lived in WNC for more than 20 years, covering politics, government and other news. He's written award-winning stories on topics ranging from gerrymandering to police use of force. Got a tip? Contact Burgess at jburgess@citizentimes.com, 828-713-1095 or on Twitter @AVLreporter. Please help support this type of journalism with a subscription to the Citizen Times.

Report from feds details many problems at NHRMC Emergency Room that put patients in 'Immediate Jeopardy'

Medicare officials have now restored NHRMC to good standing, after previously threatening to terminate contract

Report from feds details many problems at NHRMC Emergency Room that put patients in 'Immediate Jeopardy'

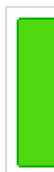
By Ann McAdams
Published: Aug. 24, 2022 at 2:37 PM EDT

WILMINGTON, N.C. (WECT) - It's a 95-page report that details exactly what state health inspectors found when they went to visit Novant Health New Hanover Regional Medical Center at the end of June. The inspection was prompted by a series of patient complaints, including one about a 77-year-old cancer patient who coded in the Emergency Room lobby after waiting over 5 hours for care. She died later that night.

The report goes on to detail what happened to more than a dozen other patients who also had bad experiences after visiting NHRMC in May and June. Most of those issues appear to be directly related to the severe nursing shortage at the hospital.

While the numbers in the report only provide a snapshot from the time inspectors reviewed, they help illustrate just how dire the staffing shortages have been in recent months. Nursing shortages have resulted in some patients having to wait for over 10 hours before being seen in the Emergency Room. Ambulances are reported to have been lined up outside the hospital, with paramedics waiting for hours to unload patients. Those delays tie up limited resources, increasing the wait time for other patients at home experiencing emergencies that require an ambulance to be dispatched.

During their week-long review, inspectors for the Department of Health and Human Services (DHHS) reviewed patient charts and interviewed caregivers at the hospital to get their input on what went wrong in many of the cases in question. WECT is providing the full report for public review, but pulled highlights we found from the report below.



“The facility failed to provide a safe environment for patients presenting to the emergency department [in many sampled cases]. ED nursing staff failed to assess, monitor and evaluate patients to identify and respond to changes in patient conditions. The facility staff failed to ensure qualified staff were available to provide care and treatment for patients who arrived in the ED. The cumulative effects of these practices resulted in an unsafe environment for ED patients,” the report reads in an overview of the problems inspectors found.

Ambulance Unloading Delays

According to the interview with Emergency Department Director #14, “[T]he expectation for EMS offloading time was 30 minutes...[and] ED staff were expected to accept the patient within 30 minutes of arrival to the facility.” But on June 13, Patient #6, an 83-year-old female, arrived at the hospital via ambulance suffering from “increased confusion.” The patient was transported to the ED hallway on a stretcher, and at the request of a nurse, evaluated by a doctor for possible stroke symptoms. The doctor determined she did not meet stroke criteria, and said the patient would have to wait for a room. The hospital does not appear to have taken the patient into their care at that time, because the paramedics stayed to supervise her.

“Interview [with Paramedic #25] revealed after the doctor evaluated Patient #6, Paramedic #25 waited with Patient #6 to get an ED bed.... Patient #6 went from acting sweet to acting ugly and took off all her clothing. Interview revealed Paramedic #25 updated the triage nurse on the change in condition. Interview revealed Paramedic #25 was worried about the neurologic state of Patient #6 with the sudden change,” page 22 of the report reads. It indicates Paramedic #25 waited with the patient for five hours before the next EMS crew took over.

Another case involved patient #31, a 92-year-old female who came to the hospital by ambulance on May 31st after fainting.

“After extensive wait time, EMS asked triage if patient could be triaged... Triage nurse declined [saying] she did not want patient to sit in the lobby with family due to [the fainting] episode as patient’s chief complaint. Charge nurse was consulted and she advised patient could not be triaged for same. EMS notified the wait time could extend another 9 hours possibly. Patient and family were advised of further extended wait times. Patient and patient’s family decided to take patient to another facility for treatment.... EMS assisted patient transferring from wheelchair to front seat of POV (privately owned vehicle). Patient #31 signed an EMS Refusal releasing them from EMS care... Patient #31 left the facility with family after waiting 3 hours and 48 minutes,” page 23 of the report reads.

The inspector’s interview with the charge nurse on June 13 revealed that when he got to work that night at 7pm, there were 164 patients in the Emergency Department and 13 ambulances waiting for their patients to be offloaded. Despite these and other reports, an interview with ED Medical Director #9 on June 29 “revealed he felt there were no delays in performing timely Medical Screening Exams on patients that presented to the ED via EMS.”

Inaccurate Wait Times

On page 28, inspectors detail an incident with patient #29, a 53-year-old man brought to the hospital on June 13 for an “altered mental status.”

“Review of the ED Timeline revealed the hospital never documented Patient #29’s arrival in the ED. Review revealed Patient #29 had blood collected for lab test at 1527 by ‘EMS Collector’. Review revealed the ED disposition was set to ‘Leave Without Being Seen [LWBS] before Triage’ on 06/14/2022 at 0101 (10 hours after EMS arrived with the patient). Review of the medical record revealed no Medical Screening Exam (MSE) and no documentation of risk and benefits were discussed with Patient #29 by hospital staff prior to him leaving the ED,” the report reads. The report indicates that paramedics had been standing by with the patient for the entire time he waited to be seen.

Patient #30 was a 76-year-old female brought to the NHRMC Emergency Room on May 23rd via ambulance for vomiting.

“Review of the ED Timeline revealed the hospital documented Patient #30’s arrival in the ED as 0139 (4 hours 47 minutes after EMS arrived with the patient). Review revealed the ED disposition was set to “LWBS before Triage” at 0142 (4 hours 50 minutes). Review of the medical record revealed no MSE and no documentation of risk and benefits were discussed with Patient #30 by hospital staff prior to her leaving the ED,” the report reads on page 29.

An interview with Paramedic #28, who transported Patient #30 to the ED, said “there were already 3 or 4 other EMS with stretchers with patients

While at the hospital, inspectors reviewed a report generated at NHRMC which showed a delay in turnaround time for ambulances at the 17th Street campus.

"Review revealed the facility identified the concern of EMS turnaround time in October 2021, and metrics to be measured included: EMS turnaround time (from EMS arrival to RN [registered nurse] handoff) and Outliers > 90 minutes. 'Background information/Baseline data: Turnaround times now average 65 minutes.' Review of 'Tactic: 'Arrive' in Epic [computer program name] at true time of arrival' revealed 'Steps: Looking for resources to 'arrive' EMS patients.' Review revealed no update was listed. Review of 'Tactic: Staffing Redesign' revealed Steps: labor market assessment tool approval to be completed by 02/25/2022. No further status updates were provided. Review of the data collected did not reflect the actual arrival time of the patients via EMS. The data collected was based on the time the nurses accepted the patients from EMS staff regardless of actual arrival time to the facility. Review revealed inaccurate data collection of patients presenting to the ED via EMS," the report reads on page 46.

"Didn't want to... lose them" in the lobby

An interview with the Performance Improvement Coordinator for Emergency Services on page 47 indicates why EMTs were being asked to stay so long after they brought their patients to the Emergency Room.

"The facility had designated a hallway in the ED for the EMS to hold the patients awaiting acceptance by the staff. Interview revealed, 'We didn`t want to put EMS patients in the ED lobby' because 'they were priority and we didn`t want to lose them' in the lobby. Interview revealed lack of staff to accept patients from EMS was identified as the main reason for EMS holding patients in the ED," the report reads.

Summer rush

Wait times got significantly worse in June, perhaps because of the influx of people to the Wilmington area during the busy summer season. A review starting 1/1/2022 through 6/26/2022 showed 1,249 EMS trips (out of a total 1,801) resulted in turnaround times greater than 30 minutes, but only 42 trips out of the year-long total at that point had resulted in wait times over four hours. A review of turnaround times dated 6/6/2022 through 6/20/2022 revealed 944 EMS trips. 404 of those trips resulted in an EMT time of greater than the 30 minute turnaround time goal. 26 of the trips had a turnaround time of greater than four hours.

The inspector's review of electronic medical record patient volumes showed that on June 14, a Tuesday, there were 200 patients being cared for in the NHRMC Emergency Room. 96 of them were true Emergency Department patients, but another 45 of them were Behavioral Health patients, and 59 more were impatient waiting to be assigned to a room. While there have been well over 100 empty beds at the hospital at many times over the last year, there have not been enough nurses to staff them.

On June 21, when the state inspector arrived on premises, the ED had 138 patients in the unit, with 64 patients at inpatient status and waiting for bed placement. The inspector reported that at 11:55 that night, there were only 13 nurses on hand to handle all of those patients.

Hiring surge

The hospital has about 2,000 nurses on staff. At the peak of the nursing shortage, NHRMC was short about 400 nurses. After a recent hiring surge, which was accelerated after federal healthcare regulators threatened to terminate the hospital's Medicare contract due to patient safety concerns, NHRMC says it has been able to reduce the number of nursing vacancies to about 100.

During a reinspection on August 11, state inspectors found that hospital officials had addressed the immediate patient safety concerns, and recommended that NHRMC be returned to good standing with the DHHS, so they could keep their Medicare contract. On Monday, the hospital received a letter from the Centers for Medicare and Medicaid services stating that the hospital is back "in compliance with the Medicare Conditions of Participation... Accordingly, we are removing your facility from State Survey Agency Jurisdiction."

New Hanover 2657 6.29.2022
Contributed by WECT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	340141	A. BUILDING ______ B. WING ______	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVANT HEALTH NEW HANOVER REGIONAL MEDICAL CENTER	2131 S 17TH ST BOX 9000 WILMINGTON, NC 28402

(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) COMPLETION DATE
A 000	INITIAL COMMENTS A complaint investigation was conducted June 21, 2022 through June 29, 2022 to determine the hospital's compliance with the Medicare Conditions of Participation. The investigation resulted in the identification of an Immediate Jeopardy (IJ) to patients' health and safety on June 24, 2022 at 1110 as a result of incidents occurring on June 6, 2022 and June 20, 2022. Specifically, pursuant to 482.13 Patient's Rights, 482.23 Nursing Services, and 482.55 Emergency Services the facility staff failed to provide patient care in a safe setting by failing to evaluate and supervise the care of a patient in the emergency department whose condition deteriorated and subsequently died; and failing to provide qualified staff available to meet the needs of patients presenting for emergency care. 1. The findings of the investigation revealed a 77 year old female (Patient #7) presented to the facility's emergency department on 06/06/2022 at 2031 for complaints of vomiting, weakness, unable to stand, fever at home and had a history of rectal cancer receiving chemotherapy. Triage vital signs revealed a Blood Pressure 87/53, Heart rate 67, Respiratory Rate 30, Temperature 98.4 at 2043. Findings revealed Patient #7 was as triaged ESI (Emergency Severity Level Index) 3 (Urgent). Repeat Blood Pressure at 2106 118/55. Patient #7 was placed in the emergency department waiting room. Findings revealed Patient #7 was not reassessed per facility triage policy. Findings revealed the next documental entry in Patient #7's medical record was on 06/07/2022 at 0200 (4 hours 54 minutes after the last blood pressure and 5 hours and 29 minutes after arrival). Code Blue Spiritual Care and	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

Attachment 6:
Comparative Analysis Factors (Suggested)

Comparative Analysis Factors (Suggested)

The following factors may also be considered:

- Quality of Care
- Site Factors

Other factors not listed above may be appropriate depending on the specifics of the review

*** Access by Underserved Groups**

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

> *"Medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority."*

Consider comparing the applications with respect to the following underserved groups. Treat each group as a separate factor.

- Medicare
- Medicaid

Consider calculating and using the following metrics for each underserved group factor. If one or more of the metrics listed below cannot be calculated for <u>each</u> application in the review for whatever reason, then you should consider not using that metric.

- Medicare Patients
- Medicare Patients as a Percentage of Total Patients
- Medicare Patients per Bed, OR, or Unit of Equipment **
- Medicare Gross Revenue
- Medicare Gross Revenue as a Percentage of Total Gross Revenue
- Medicare Gross Revenue per Bed, OR, or Unit of Equipment **

- Medicaid Patients
- Medicaid Patients as a Percentage of Total Patients
- Medicaid Patients per Bed, OR, or Unit of equipment **
- Medicaid Gross Revenue
- Medicaid Gross Revenue as a Percentage of Total Gross Revenue
- Medicaid Gross Revenue per Bed, OR, or Unit of Equipment **

** Do not use this metric for home health or hospice home care proposals

Comparative Analysis Factors (Suggested)

Objective: Provide analysts and co-signers with a list of suggested comparative factors.

The following factors are suggested for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility (Location within the Service Area)
- Access by Service Area Residents
- Access by Underserved Groups – Medicaid *
- Access by Underserved Groups – Medicare *
- Competition (Access to a New or Alternate Provider)
- Projected Average Net Revenue per Patient, Procedure, Case or Visit
- Projected Average Total Operating Cost per Patient, Procedure, Case or Visit

The following additional factors are suggested based on the type of proposal:

Operating Room Proposals

Patient Access to Lower Cost Surgical Services
Multispecialty versus Specialty (ASFs only)

Dialysis Proposals

Access to Home Training and Support Services
Hours of Operation (# of Shifts per Day)

Home Health and Hospice Home Care Proposals

Average Number of Visits per Patient

Nursing Facility and Adult Care Home Beds Proposals

Number of Private Beds as a Percentage of Total Beds

Inpatient Rehabilitation Proposals

Continuity of Care
Access by Pediatric Patients
Number of Private Beds as a Percentage of Total Beds

Mobile Equipment Proposals

Total Number of Proposed Host Sites
Number of New Host Sites (i.e., no existing service at that site)