MISSION
HOSPITAL

March 26, 2024

Mr. William Sims
c/o Michelle Joshua (Michelle.Joshua@cms.hhs.gov)
CMS Atlanta, Survey Operations Group
Centers for Medicare & Medicaid Services

RE: Mission Hospital

Dear Mr. Sims,

Enclosed is Mission Hospital's amended plan of corrective action in response to your feedback for the deficiencies correspondence dated March 25, 2024, for the following Conditions of Participation:

42 C.F.R. § 489.24(a) & 489.24(c): Medical Screening Exam (Tag 2406); and
42 C.F.R. § 489.20(l): Compliance with 489.24 (Tag 2400)

This letter along with attached 2567 describe the numerous actions the hospital has taken to ensure compliance with the above Conditions of Participation and provides credible evidence of full compliance with all of the Medicare Conditions of Coverage/Participation and regulations. All audits and associated materials will be available to the surveyors upon the revisit.

The concerns of CMS have been taken very seriously by the hospital Administration, the Medical Executive Committee of the Medical Staff, and the Board of Trustees. You can be assured that the highest priority has been assigned to correcting the deficiencies identified at Mission Hospital.

We are routinely monitoring compliance of the Medicare Conditions of Participation. This information is reported to the Leadership team and will be reported to our Medical Executive Committee and the Board of Trustees.

Based on the explanations herein and the actions of the hospital, we believe there is credible evidence of compliance with the requirements of Medicare and that the hospital has ensured quality care for all patients treated by Mission Hospital.

If you require additional information or if we can be of assistance, please do not hesitate to call us at **828-989-8249.**

Sincerely,

Chad Patrick, CEO Enc: CMS
2567

Cc: Azzie Conley,
Division of Health Service Regulation-Acute & Home Care Licensure & Certification Section, NCDHHS

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
	340002	A. BUILDING _____ B. WING _____	C 11/27/2023

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 000	INITIAL COMMENTS A complaint investigation was conducted November 13 - 17, 2023 and November 27, 2023, to evaluate Memorial Mission Hospital and Asheville Surgery Center's compliance with 42 CFR 489.20 and 42 CFR 489.24 which pertain to the Federal Emergency Medical Treatment and Labor Act (EMTALA). Intakes NC187063, NC193674, NC207301 and NC208811 did not result in non-compliance with the Emergency Medical Treatment and Labor Act. Intake NC209495 did result in an EMTALA violation, see A2400 and A2406 for findings. A plan of correction is required for the identified non-compliance. During an on-site complaint survey related to CMS Hospital Conditions of Participation (CoP), survey exit date December 9, 2023, the North Carolina State Survey Agency (SA) identified Immediate Jeopardy (IJ) level findings related to 42 CFR 482.55, Emergency Services. The hospital provided CMS with an acceptable IJ removal plan on February 12, 2024. On February 24, 2024, the CMS and SA completed an on-site survey to verify IJ had been successfully removed, with on-going CoP level non-compliance at 482.12 Governing Body, 482.13 Patient Rights, 482.21 Quality Assessment and Performance Improvement Program, 482.27 Laboratory Services, and 482.55 Emergency Services. The hospital was able to successfully demonstrate IJ had been removed under 482.55 Emergency Services during the February 24,	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 presented to 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 presented to 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

Jan C. Patel — 3/26/24

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 000	Continued From page 1 2024, visit as evidenced by: 1. Monitoring of patient condition beginning with Registered Nurse (RN) triage and time stamp process to capture accurate arrival times that includes rapid triage process. 2. Triage line of greater than three (3) patients prompt escalation pathway for additional support, structured communication involving Emergency Department (ED) leadership to include safety, patient throughput, pending medications, reassessments, diagnostics, and all escalations via internal communication tool. 3. Arrival to EKG time 10 minutes with structured communication regarding review and escalation of outstanding EKG orders. 4. Order to lab draw time 30 minutes with structured communication regarding review and escalation of outstanding order to lab collection. 5. ED tracking board enhancements to include vital signs, telemetry, pain reassessment, and EKG icons. 6. Developed process to off-load EMS patients. 7. Instituted rapid triage process. 8. Opened additional inpatient beds to reduce ED patient holds. 9. Hired Regional EMS Coordinator for communication and coordination with EMS. 10. Developed triggers for triage escalation and posted at triage desk. 11. Purchased four (4) portable cardiac monitors. 12. Added additional monitors to display and allow total visibility of ER patients with unassigned beds in waiting room, EMS entrance and pre-arrivals. 13. Created intake teams to perform Medical Screening Exam (MSE), nursing documentation, and implement initial interventions. 14. Provided staff education and implemented	A 000	As referenced on the March 14, 2024 call with CMS, and as recognized in the 2567 summary statement of deficiencies, the hospital was able to successfully mitigate the Immediate Jeopardy. The immediate and ongoing actions to mitigate and sustain compliance are: • Review of Arrival to Triage performance, audit, and process changes for EMS and Walk in patients December 2, 2023 • **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 Timestamp implementation process -** • **Education for staff regarding process for accurately reflecting patient time of arrival to time of triage** • **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.** • Education Assignment of Sullivan Group © Triage Training – January 1, 2024 • Review of Arrival to EKG audit process. January 1, 2024 • Review of Lab order to collect audit process and Turn Around Time Goals. February 6, 2024	

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A 000	Continued From page 2 monitoring processes.	A 000	• Laboratory staff education on new analyzer functionality to increase automation. February 16. 2024 • EMTALA training presentation provided by CMO at ED Provider Service Line meeting. February 21, 2024 • 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.	
A2400	COMPLIANCE WITH 489.24 CFR(s): 489.20(l) [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on policy reviews, medical record reviews, and staff and physician interviews, the hospital failed to comply with 42 CFR 489.20 and 489.24. The findings included: The hospital's Dedicated Emergency Department (DED) failed to provide a timely appropriate Medical Screening Examination (MSE) within the capability of the hospital's DED, including ancillary services routinely available to the DED, to determine whether an Emergency Medical Condition (EMC) existed for one (1) of 38 sampled DED patients who presented to the hospital for evaluation and treatment, (Patient #2). ~ Cross refer to 489.24(a) and 489.24(c) Medical Screening Examination - Tag A 2406.	A2400	• **Since January 2024 the hospital's EMS coordinator has reached out to all 20 EMS agencies that serve Western North Carolina. Meetings have included updates on Mission Hospital's ED initiatives to expedite arrival to triage as well as initiatives to utilize prehospital care providers expertise for critical patient care environments like code strokes, and code traumas to ensure safe and timely patient care transitions.** Upon receipt of the March 14, 2024 2567 EMTALA citation, the following additional actions began: • Tracking and trending of appropriate Emergency Severity Index (ESI) level assignment of patients	
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c) (a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must- (i) Provide an appropriate medical screening	A2406	• Tracking and trending of appropriate and timely Medical Screening Exams (MSEs) of patients • Remedial education was provided specific to the appropriate assignment of ESI levels and appropriate and timely MSEs. • **Reviewed and updated Mission Hospital Surge Plan to ensure adequacy of resources and the safe delivery of care during high influx of patients.**	

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A2406	Continued From page 3 examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic	A2400 A2406	Summary of policies/guidelines and any other documents reviewed or revised during POC development: • EMTALA - Medical Screening Examination and Stabilization - LL.EM.001.NC.02 • Triage – Emergency Department - 1PC.ED.0401 • Triage Treatment Guidelines -TTGs - 1PC.ED.0402 • **Mission Hospital Surge Plan** **Subject of Deficiency A 2400:** The hospital's Dedicated Emergency Department (DED) failed to provide a timely appropriate Medical Screening Examination (MSE) within the capability of the hospital's DED, including ancillary services routinely available to the DED, to determine whether an Emergency Medical Condition (EMC) existed for one (1) of 38 sampled DED patients who presented to the hospital for evaluation and treatment. ~ Cross refer to 489.24(a) and 489.24(c) Medical Screening Examination - Tag A 2406. **Subject of Deficiency A 2406:** The hospital's Dedicated Emergency Department (DED) failed to provide a timely appropriate Medical Screening Examination (MSE) within the capability of the hospital's DED, including ancillary services routinely available to the DED, to determine whether or not an Emergency Medical Condition (EMC) existed for one (1) of 38 sampled DED patients who presented to the hospital for evaluation and treatment.	

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A2406	Continued From page 4 infectious disease, pursuant to a State pandemic preparedness plan. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act. (E) There has been a determination that a waiver of sanctions is necessary. (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act. (c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on policy and procedure reviews, medical record reviews and staff and physician interviews the hospital's Dedicated Emergency Department (DED) failed to provide a timely appropriate Medical Screening Examination (MSE) within the capability of the hospital's DED, including		**Plan of Correction:** **Immediate Actions Taken** Upon receipt of the 2567 the following actions were taken to mitigate the findings: **Staff Education:** **General** EMTALA education provided to currently working eligible and targeted **ED staff (RNs, Paramedics, Techs and HUCs) and Security, Greeters, Registration, EVS that are assigned to work in ED** using multiple mechanisms. These mechanisms included Sullivan Group © Triage Training, HealthStream, Zenith, huddles, email, 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. It was confirmed that this education is reviewed with every new hire during general hospital orientation and provider onboarding. • **Comprehensive Education for ED nursing staff (RNs) regarding EMTALA** • **Sullivan Group © Triage Training for all RNs on appropriate ESI level assignments, schedule assigned per education plan** • **All ED staff (RNs, Paramedics, HUCs, Techs) received general EMTALA training: Nuts & Bolts**	3/26/24

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A2406	Continued From page 5 ancillary services routinely available to the DED, to determine whether or not an Emergency Medical Condition (EMC) existed for one (1) of 38 sampled DED patients who presented to the hospital for evaluation and treatment, (Patient #2). The findings included: Review of the policy "EMTALA (Emergency Medical Treatment and Labor Act) - Medical Screening and Stabilization...", last approved 12/13/2021, revealed ". 3. Extent of the MSE (Medical Screening Examination) a. Determine if an EMC (Emergency Medical Condition) exists. The hospital must perform an MSE to determine if an EMC exists. b. Definition of MSE. An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital. c. An on-going process. The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer. ...5. No Delay in Medical Screening or Examination..... c. EMS. A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing	A2406	**due by 4/31/24** • **Huddle Card – EMTALA Basics Education for RNs, Paramedics, HUCs, Techs, EVS, Security, Registration and Greeters**	3/26/24

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A2406	Continued From page 6 EMS to leave the individual, could be in violation of EMTALA .... Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE. ... " Review of the EMS (Emergency Medical Services) Patient Care Record, on 11/14/2023, revealed EMS was called to Patient #2's home on 10/17/2023. The 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.... SYNCOPAL EPISODE (episode of unconsciousness with recovery) WITH CHEST PAIN AND SHORTNESS OF BREATH ...ARRIVED.... TO FIND A 66-YEAR-OLD MALE, A&Ox4 (alert and oriented to person, place, time, situation), SKIN PALE, WARM, AND DRY PT ADVISED HE HAD BEEN HAVING CHEST PAIN AND SHORTNESS OF BREATH FOR THE LAST WEEK.... ADVISED THAT HE HAD BEEN WORKING AROUND THE HOUSE AND ALL OF A SUDDEN HE DID NOT FEEL GOOD AND PASSED OUT.... PT ADVISED HE RECENTLY HAD SURGERY ON HIS FOOT AND IT.... GOT AN INFECTION AND WAS TAKING ANTIBIOTICS FOR SAME. PT ADVISED HE WAS GOING TO NEED ANOTHER SURGERY.... 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	A2406	**Ongoing Actions:** Monitoring of patient condition beginning with RN triage and assignment of appropriate ESI levels. Results of audits provided in feedback sessions with nursing staff using the Sullivan Group © reports. Staff provided with the opportunity to review fallouts as part of ongoing process improvement. **Monitoring for Compliance:** • The goal of our audit is to reach 90% compliance with 100% remediation of outliers/deviation from process. There will be a review and remediation specific to outliers for 3 months with quarterly monitoring for subsequent four quarters. • Numerator = # of appropriately assigned ESI levels Denominator = 70 ESI level audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT). **Owner**: CNO/ACNO/VP ED **Medical Staff Education:** **General** EMTALA ED provider education is conducted upon initial hire, annually, and during the recredentialing process. EMTALA remedial education **related to A-2406 finding provided to providers (MD, DO, PA, APRN) currently assigned to work in the ED** regarding timely and appropriate MSE using multiple mechanisms. These mechanisms include email, flyers, and medical staff presentations. **Additional just in time EMTALA education was used to educate 100% of working ED providers**. Providers 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.	3/26/24

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A2406	Continued From page 7 IMPROVEMENT IN BREATHING.... PT WAS FOUND ..... HYPERGLYCEMIC (high blood sugar) .....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 (on a scale of 0-10 with 0 being no pain and 10 being the worst pain) AND THAT TAKING A DEEP BREATH HURT ...THIS HAS BEEN GOING ON ALL WEEK AND HAS NOT CHANGED..... 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 at 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 to the hospital's ED. The last recorded EMS vital signs were at 1858 with BP 104/61, pulse 70, respirations 15, 99% pulse ox and a pain score of 6. Review of the Dedicated Emergency Department (DED) medical record, on 11/14/2023, revealed Patient #2 arrived by EMS to the hospital on 10/17/2023 at 1753. Review of the "ER Report" by a Physician Assistant (PA), 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	A2406	**Just in time education specific to A-2406 finding for** appropriate and timely MSEs. **Ongoing Actions:** Monitoring of appropriate and timely MSE completion. **Monitoring for Compliance:** • The goal of the audit is to reach a minimum of 90% compliance with 100% remediation of outliers/deviation from process. There will be a review and remediation specific to outliers for 3 months with quarterly monitoring for subsequent four quarters. • Numerator = # of compliant MSEs Denominator = 70 audits/month • Results reported through Quality Council, Medical Executive Committee (MEC), and Board of Trustees (BOT). **Owner:** Medical Director ED or provider designee/CMO/ACMO **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)**	

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A2406	Continued From page 8	A2406		

and reports that these symptoms are aggravated with exertion. ... he states that today he had acute worsening to his symptoms.....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 (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 (ventricular tachycardia - where lower chambers of the heart beat very quickly)....."

Review of the "ED Triage", performed 10/17/2023 at 1900 (1 hour and 7 minutes after EMS arrival) revealed a pre-hospital blood glucose of 459 and an acuity of "3-urgent". Vital signs were recorded as: 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 noted as seven (7).

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	340002	A. BUILDING _____ B. WING _____	C 11/27/2023

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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A2406	Continued From page 9 Further review of the PA's "ER Report" note revealed "...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 of orders revealed a stat order for an EKG at 1841 (48 minutes after Patient #2 arrived to the ED). Review revealed a hospital EKG was completed at 1905 (24 minutes after order and 1 hour 12 minutes after arrival). Review of lab orders revealed the following lab tests were ordered stat at 1841: 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 stat orders). Patient #2 experienced cardiac arrest at 1953, 2 hours after arrival. The labs resulted later, the CBC at 2002 and the CMP at 2012. The D-Dimer resulted at 2006 as 824 (high). The Pro BNP resulted at 2023 as 9690 (High - reference range 5-125) and the Troponin resulted at 2039 as 0.460 (High - reference range 0.000-0.034). The physician was notified. Review of the "ER Report", service date/time 10/17/2023 at 2030, revealed a note by a physician that indicated ". 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 (cardio- pulmonary resuscitation) was initiated. The patient was	A2406		

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A2406	Continued From page 10	A2406		

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 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 (2024) .....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. ..."

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A2406	Continued From page 11 Telephone interview on 11/20/2023 at 1415 with EMS #70 revealed EMS 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, 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 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 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 on 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	A2406		

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A2406	Continued From page 12 revealed these type 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 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 not a 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. The RN stated labs were not drawn until after the patient was accepted and in a room. Until 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. In summary, Patient #2 was brought to the ED by EMS from home. The patient arrived on 10/17/2023 at 1753 with chest pain after a syncopal episode at home. The provider ordered labs at 1841 (48 minutes after Patient #2 arrived). The patient was triaged at 1900 and labs were	A2406		

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A2406	Continued From page 13 collected at 1920 by nursing staff. Patient #2 was on a cardiac monitor and received vital signs by EMS until triage at 1900. No hospital EKG was completed until 1905 (1 hour 12 minutes after arrival). The D-Dimer, Pro BNP and Troponin all resulted after 2000 and all resulted abnormally high. Patient #2 experienced cardiac arrest around 1953 (2 hours after arrival to the DED). CPR was initiated but was not successful and Patient #2 expired. There was a delay in triage, medical screening and interventions, including hospital EKG and labs for a patient who arrived at the hospital via EMS for chest pain and syncope.			