WRITTEN COMMENTS ON 2025 BUNCOMBE-GRAHAM-MADISON-YANCEY COUNTY ACUTE CARE BED COMPETITIVE REVIEW

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

December 1, 2025

Four applicants submitted CON applications in response to the need identified in the 2025 SMFP for 129 additional acute care beds in the Buncombe, Graham, Madison, and Yancey multicounty service area. The applicants include:

- CON Project ID# B-012708-25 UNC Heath West
- CON Project ID# B-012709-25 Novant Health Asheville Medical Center
- CON Project ID# B-012716-25 AdventHealth Asheville
- CON Project ID# B-012720-25 Mission Hospital

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 conformity 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.

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COMMENTS SPECIFIC TO UNC HEALTH WEST (UNCHW)
PROJECT ID # B-012708-25

UNC's Proposal Raises Significant Cost and Priority Concerns

UNC's proposal would require approximately $700 million, funded by a state-owned organization at a time when North Carolina is already facing substantial budget pressures. UNCHW emphasizes that its majority member, UNC Health, is "North Carolina's only state-owned, full-service healthcare system," yet never explains why a governmental hospital should be preferred over a community-based non-profit capable of delivering the same or greater scope of services without drawing on limited state resources.

UNC's request is especially troubling because the proposed hospital would be built in one of the most affluent areas of Buncombe County, surrounded by ZIP codes, such as 28803, 28806, and 28704, with strong commercial insurance coverage, higher incomes, and ready access to multiple existing hospitals.

The Asheville urban corridor, including the zip codes surrounding the proposed site, has a substantially lower rate of Medicaid coverage than Buncombe County as a whole. The zip codes near UNC's Brevard Road location report Medicaid rates of 13.8 to 15.0 percent, compared to 21.5 percent countywide. By siting its project in one of the least Medicaid-dependent areas of the county, UNC is directing resources toward the region's most commercially favorable territory rather than toward the medically underserved communities within the CON service area, particularly Madison County, where Medicaid dependence is significantly higher and access barriers are well documented.

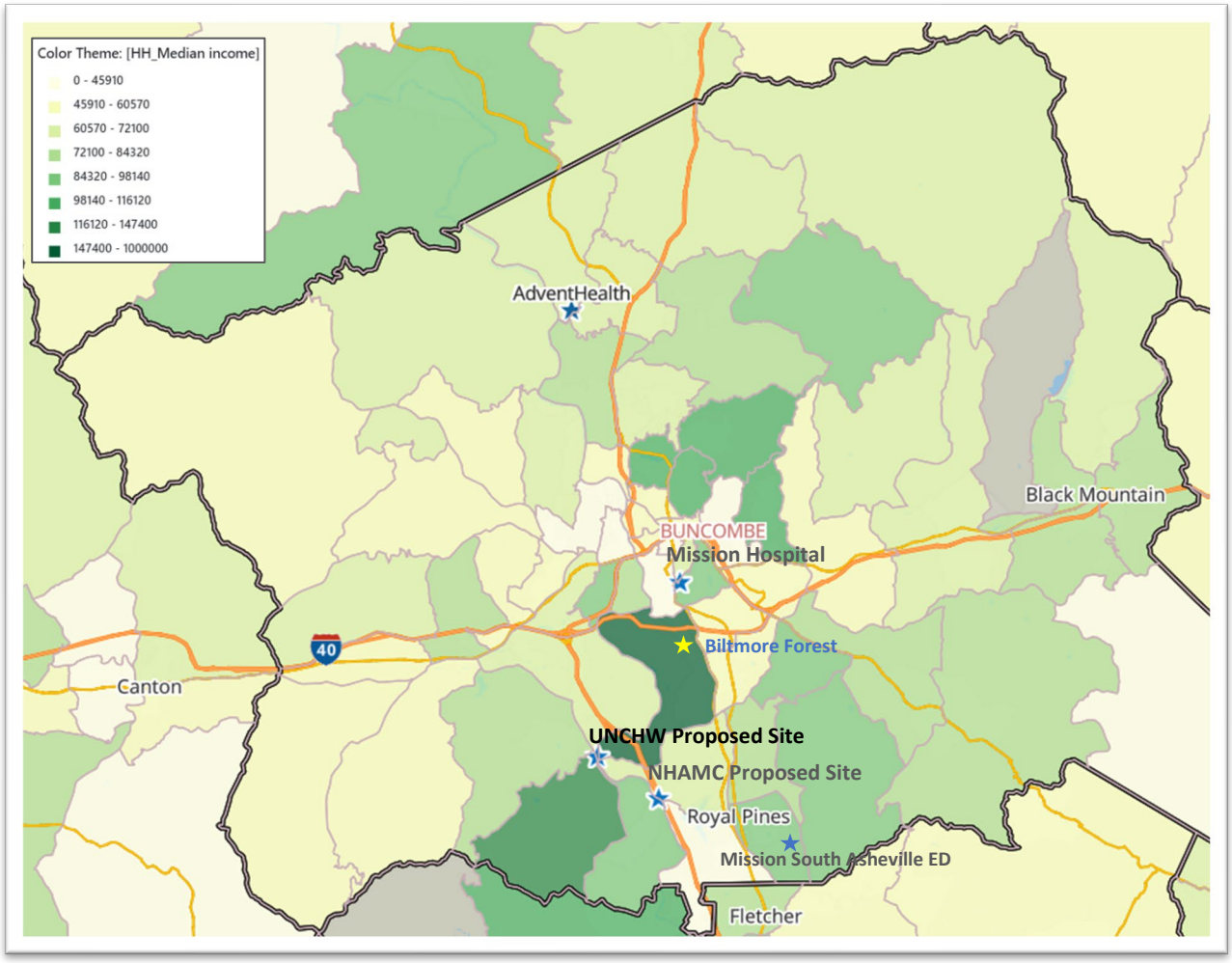
Area	% Medicaid Population
Zip Code 28803	13.8%
Zip Code 28806*	13.9%
Zip Code 28715	14.0%
Zip Code 28704	15.0%
Buncombe County	21.5%
Graham County	15.1%
Madison County	19.0%
Yancey County	12.0%

*UNCHW proposed site location
Source: US Census Bureau, American Community Survey, 2023 (data.census.gov)

The proposed UNC site is located immediately adjacent to one of the wealthiest communities in North Carolina. ZIP code 28806 borders Biltmore Forest (located in ZIP 28803), a municipality with a median household income of approximately $172,500, which is more than double the amount in the Asheville Metro Area.[1] An independent analysis has identified Biltmore Forest as the richest municipality in the state.[2] The following map portrays median household income by census tract and illustrates the fact that the areas immediately adjacent to the proposed site are the most affluent in Buncombe County.

[1] US Census Bureau, American Community Survey, 2023 (censusreporter.org)
[2] Forbes, "The Richest Cities in North Carolina, Per the Latest Census Data," Oct. 17, 2023

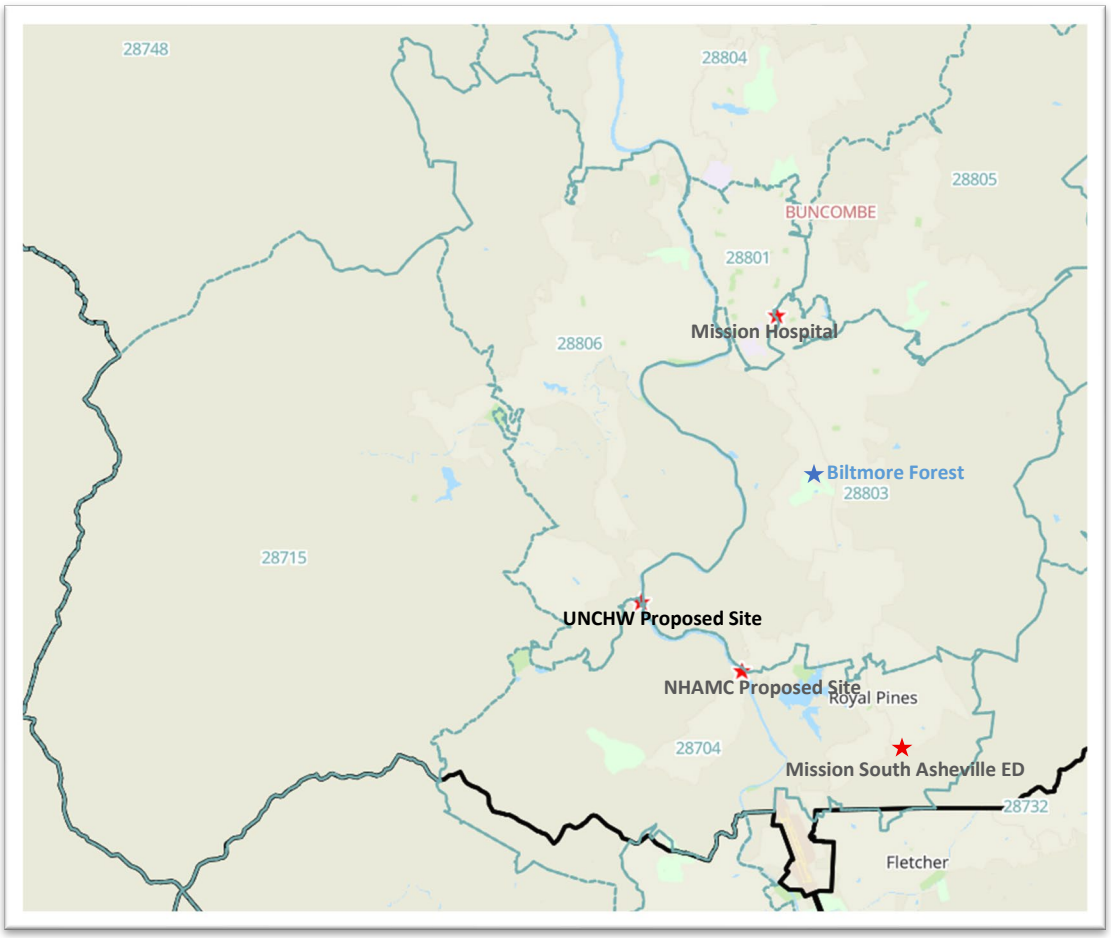
Median Household Income by Census Tract, 2025



Source: Maptitude® mapping software

There is a direct route between the proposed UNCHW facility and Biltmore Forest making travel times between them less than 10 minutes. Mission's freestanding ED is also within 10 minutes, underscoring the density of existing hospital access already available to residents of this area.

Zip Code Map and UNCHW Proposed Hospital Location



Source: CON applications, Maptitude® mapping software

Given these conditions, UNC's siting decision reinforces an inescapable fact: the project is not designed to expand access for medically underserved communities. Instead, it concentrates nearly $700 million of public investment in a part of the region that already benefits from strong commercial insurance coverage, close proximity to multiple emergency departments, and comparatively low barriers to hospital care, while residents of Madison, Yancey, and Graham Counties continue to face some of the longest travel times and the least reliable access in the service area.

This choice has real consequences. The amount UNC seeks for this project is nearly equivalent to the investment needed for the planned state-funded children's hospital, a project of far greater statewide significance and one that would serve children across all 100 counties. Legislators have already expressed concerns that UNC's request could complicate or delay funding for that long-awaited pediatric facility.[3] Every dollar directed to duplicating hospital services in affluent South Asheville is a dollar not available for the children's hospital the General Assembly has publicly committed to deliver.

[3] Michels, Sarah. NC lawmakers fail to fund Medicaid as deadline nears, point fingers at each other. Carolina Public Press, September 23, 2025.
Specht, Paul and Jack Hagel. Republican NC lawmakers spar over Medicaid, children's hospital funding as budget impasse drags on. WRAL, September 17, 2025.

Put simply: If UNC proceeds with this $700 million hospital in the wealthiest corridor of Buncombe County, it is North Carolina's children who lose out. The State will be forced to choose between financing duplicative acute care capacity for patients who already have hospital access, or investing in pediatric specialty care that children across the entire state desperately need.

The question is unavoidable: Why should the State divert nearly $700 million to build a duplicative hospital near an underutilized UNC hospital, especially when the same funds could instead support the development of North Carolina's children's hospital?

AdventHealth's model avoids this zero-sum tradeoff entirely. Private capital, not state funds, will finance the most competitive proposal in this review. The service area receives long-overdue competition and improved access without compromising statewide pediatric priorities or requiring taxpayers to subsidize duplicative facilities in affluent areas.

UNC Health Pardee Bed Surplus

The UNCHW application fails to address a critical and unavoidable issue: Margaret R. Pardee Memorial Hospital (UNC Health Pardee), an existing UNC-affiliated acute care hospital located only 23 minutes from the proposed site, is significantly underutilized and already possesses a large surplus of acute care bed capacity, and is included in the UNCHW service area. Despite these facts, the applicants offer no explanation of how developing a second UNC-affiliated acute care hospital with an overlapping service area will affect the existing hospital or how the proposed project will avoid unnecessary duplication of services.

According to the 2025 SMFP, UNC Health Pardee provided 23,809 acute care days in FFY2023, equivalent to only 32.5% occupancy of its 201 licensed acute care beds. This is one of the lowest occupancy levels among similarly sized hospitals in the region.

County	Hospital	Licensed Acute Care Beds	FFY2023 Days of Care	% Occupancy
Catawba	Frye Regional Medical Center	203	36,216	48.9%
Caldwell	UNC Health Caldwell	110	20,674	51.5%
Haywood	Haywood Regional Medical Center	120	20,748	47.4%
Henderson	**UNC Health Pardee**	**201**	**23,809**	**32.5%**
Rowan	Novant Health Rowan Medical Center	198	38,963	53.9%
Watauga	Watauga Medical Center	113	18,261	44.3%

Source: 2025 SMFP

Even more striking, despite the Proposed 2026 SMFP's projected 6.19 percent annual growth in Henderson County acute care days through FFY 2028, UNC Health Pardee is still projected to have a surplus of 57 acute care beds by FY2028, more than 28 percent of its entire licensed capacity. *See* page 39 of the Proposed 2026 SMFP.

UNC's own recent filings confirm that UNC Health Pardee is not a strictly Henderson County-only hospital. In its 2025 fixed cardiac catheterization application (Project ID #B-12676-25), UNC Health Pardee reported serving more than 33,000 Buncombe County patients in its last full fiscal year. See also the following table excerpted from UNC Health Pardee's 2025 fixed cardiac catheterization application.

Entire Facility or Campus	<UNC Health Pardee> *	
	Last Full FY** 07/01/2023 to 06/30/2024	
County or other geographic area such as ZIP code	Number of Patients	% of Total
Henderson	203,201	65.1%
Transylvania	40,227	12.9%
Buncombe	33,632	10.8%
Polk	13,244	4.2%
Rutherford	6,108	2.0%
Haywood	2,135	0.7%
Other^	13,669	4.4%
Total	**312,216**	**100.0%**

* This should match the name provided in Section A, Question 4.

^ Other includes Jackson, Madison, Haywood, Swain, Cumberland, Franklin, McDowell, Catawba, and other North Carolina counties, as well as other states.

** SFY 2024 represents the last full year of comprehensive data available during application preparation. While SFY 2025 volume data was available and used for baseline projections, other required year-end financial and utilization data for the table above remained unavailable due to ongoing close-out processes.

Source: Project ID # B-12676-25, page 36

Buncombe County patients represented nearly 11 percent of all Pardee patients, making Buncombe Pardee's third-largest county of origin.

At the same time, over 65 percent of Pardee's patient origin comes from Henderson County. Thus, UNC Health Pardee draws heavily from both Henderson and Buncombe, the same two counties from which UNCHW expects the vast majority of its volume.

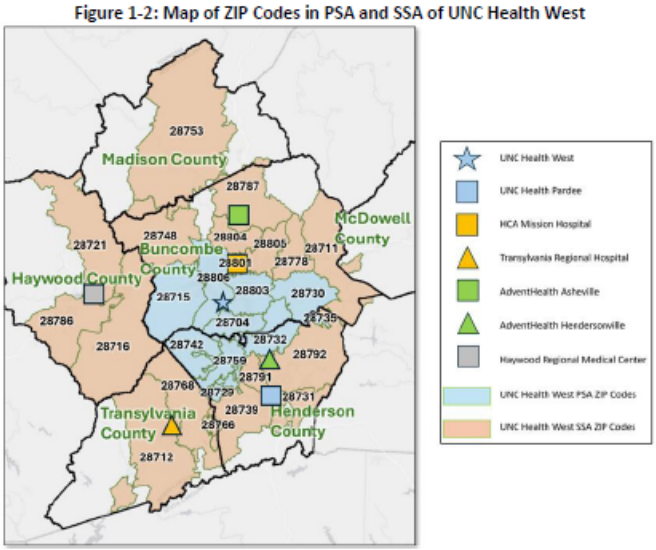
UNCHW identifies a service area that includes nine Henderson County ZIP codes, as demonstrated in the following table excerpted from the UNCHW application.

Table 1-3: ZIP Codes in UNC Health West PSA and SSA

ZIP Code	County	Service Area
28704	Buncombe	PSA
28715	Buncombe	PSA
28729	Henderson	PSA
28730	Buncombe	PSA
28732	Henderson	PSA
28735	Henderson	PSA
28742	Henderson	PSA
28759	Henderson	PSA
28803	Buncombe	PSA
28806	Buncombe	PSA
28711	Buncombe	SSA
28712	Transylvania	SSA
28716	Haywood	SSA
28721	Haywood	SSA
28731	Henderson	SSA
28739	Henderson	SSA
28748	Buncombe	SSA
28753	Madison	SSA
28766	Transylvania	SSA
28768	Transylvania	SSA
28778	Buncombe	SSA
28786	Haywood	SSA
28787	Buncombe	SSA
28791	Henderson	SSA
28792	Henderson	SSA
28801	Buncombe	SSA
28804	Buncombe	SSA
28805	Buncombe	SSA

Source: UNCHW Application, page 155

Figure 1-2: Map of ZIP Codes in PSA and SSA of UNC Health West



Source: UNCHW Application, page 156

The proposed UNCHW facility will be located in Buncombe County near the intersection of Brevard Road and Frederick Law Olmstead Way, a 23-minute drive to UNC Health Pardee. UNCHW projects that over 60% of its patients will originate from Buncombe County and over 15% will originate from Henderson County, per its total facility patient origin projections excepted below from page 50.

Entire Facility or Campus	UNC Health West Medical Center*					
	1st Full FY		2nd Full FY		3rd Full FY	
	07/01/2031 to 06/30/2032		07/01/2032 to 06/30/2033		07/01/2033 to 06/30/2034	
County or other geographic area such as ZIP code	Number of Patients **	% of Total	Number of Patients **	% of Total	Number of Patients **	% of Total
Buncombe	33,611	64.2%	59,661	62.7%	96,122	61.8%
Henderson	8,276	15.8%	15,064	15.8%	24,396	15.7%
Haywood	3,075	5.9%	5,895	6.2%	9,645	6.2%
Transylvania	1,527	2.9%	2,918	3.1%	4,772	3.1%
Madison	613	1.2%	1,175	1.2%	1,922	1.2%
Other^	5,242	10.0%	10,486	11.0%	18,688	12.0%
Total	**52,344**	**100.0%**	**95,199**	**100.0%**	**155,545**	**100.0%**

* This should match the name provided in Section A, Question 4.
** Home health agencies should report the number of unduplicated clients.
^ "Other" includes projected patients from inmigration outside of the PSA and SSA, including ZIP codes in the five counties above, as well as Graham and Yancey counties, other North Carolina counties, and other states.

Given UNC Health Pardee's low utilization, substantial surplus of licensed capacity, established patient origin patterns, and overlap with the UNCHW service area, it would be reasonable to expect UNC to direct any incremental demand to Pardee rather than duplicate services just 23 minutes away with a second UNC-affiliated general hospital. Despite this, the UNCHW application provides no discussion of the factors that are central to understanding whether a new hospital is truly needed.

Specifically, the application never acknowledges:

- Pardee's 57-bed surplus,
- Its historically low occupancy levels,
- The more than 203,000 Henderson County patients already treated at Pardee in the last full fiscal year,
- The significant ZIP-code overlap between Pardee's service area and the proposed UNCHW service area, or
- The implications of opening a new hospital so close to an underutilized facility that UNC itself manages and operates.

The omission of these issues is particularly problematic because Pardee's underutilization directly undermines the credibility of UNCHW's own projections. UNCHW forecasts 32,319 acute care days in its third project year, nearly 17 percent more than Pardee delivered in FFY 2024, despite having fewer beds and proposing to serve a market already served by multiple full-service hospitals.

Given the discussion above, UNCHW fails to demonstrate the need for its project and that it will not result in unnecessary duplication. The UNCHW application is **non-conforming with Criteria (1), (3), (4), (5), (6), (18a), and 10A NCAC 14C .3803.**

Clarification Regarding AdventHealth's Presence in Henderson County

It may be suggested that AdventHealth is not in a position to critique UNC's proposal because AdventHealth also operates a hospital in Henderson County. However, any such comparison is misplaced and overlooks key distinctions that make AdventHealth's circumstances fundamentally different from those involving UNC Health Pardee and the proposed UNC Health West facility.

First, AdventHealth Asheville does not include Henderson County in its defined service area. The AdventHealth Asheville acute care bed service area consists of Buncombe, Graham, Madison, and Yancey Counties. Henderson County is not part of AdventHealth's service area for the conditionally approved Weaverville facility. As a result, AdventHealth is not proposing to draw patients away from its own Henderson County hospital, nor is it seeking to shift volume between two AdventHealth hospitals. While the new hospital will serve Henderson County patients, it is not reasonable to expect such significant volumes from Henderson County because of the locations of AdventHealth Hendersonville and Pardee. In contrast, UNC Health West proposes to develop a new hospital in Buncombe County with a service area that overlaps extensively with UNC Health Pardee, an existing UNC-affiliated hospital located just 23 minutes away and currently operating far below efficient utilization.

Second, AdventHealth Hendersonville is well utilized and is not an underperforming facility. In fact, AdventHealth Hendersonville's strong utilization generated a need determination for 19 additional acute care beds in Henderson County in the Proposed 2026 SMFP. This result is a clear indicator of sustained demand and a consistently efficient use of existing licensed capacity. AdventHealth Hendersonville is not operating with a large surplus of unused beds, nor does it depress countywide planning need. Quite the opposite, its performance contributed to a positive need determination.

This stands in stark contrast to UNC Health Pardee, whose low utilization and structural overbedding contribute directly to a 57-bed surplus in the Proposed 2026 SMFP. Despite Pardee's significant excess capacity and occupancy levels hovering around 37.7 percent, UNC is proposing to build a second UNC-affiliated hospital that would serve the same ZIP codes and the same patient populations that Pardee serves.

Third, AdventHealth has not requested a second acute care hospital in Henderson County or any adjacent county with the intent of redirecting volume away from its own facility. UNC Health West, by contrast, would create an internal redistribution problem, pulling patients from an existing UNC-owned hospital that is already underutilized. The issue at hand is not the mere presence of two hospitals in the same county or region; rather, it is the unusual and inefficient duplication created when a single system chooses to develop a brand-new acute care hospital near an underperforming facility it already owns, without any explanation of how the two will coexist.

For these reasons, the situations are not comparable. AdventHealth's operations in Henderson County reflect a well-utilized hospital that generated additional SMFP need, while its Asheville hospital's service area does not include Henderson County at all. UNC, by contrast, is proposing a new UNC-affiliated hospital in an area already served by UNC Health Pardee, despite Pardee's extremely low occupancy and large surplus of beds, without any discussion of systemwide impacts or internal duplication.

Contradictory Statements on the Need for Competition

UNCHW argues that reducing the concentration of healthcare resources by introducing competition results in higher quality healthcare. However, in its currently proposed 2025 Cardiac Catheterization CON (Project ID # B-12676-25), UNC Health Pardee plainly states that concentrating capacity at one provider would be beneficial to patients.

In its response to Section C.4, under the heading **Need for a New Hospital as Demonstrated by the SMFP Acute Care Need Determination**, UNCHW states that "*no acute care bed service area in the entire state of North Carolina has as much of a lack of competition for acute care beds as the Buncombe/Graham/Madison/Yancey multicounty service area*" (emphasis from original, page 54) and argues that this lack of competition is bad for patients stating:

> *This level of hospital concentration has been shown to, unfortunately, lead to worse patient outcomes. For example, hospitals in competitive markets, on average, have lower mortality rates for patients with myocardial infarctions, heart failure, and pneumonia. Additionally, a 2018 study found that more concentrated markets for cardiology services specifically led to a five to seven percent increase in risk- adjusted mortality. Given the concentration of services in the service area of the proposed project, it follows that these worse patient outcomes may currently translate to Buncombe, Graham, Madison, and Yancey counties.*

However, UNC makes the opposite argument in its currently proposed 2025 fixed cardiac catheterization CON (Project ID # B-12676-25). In that filing, UNC Health Pardee argues that concentrating cardiac catheterization capacity at a single provider, UNC Health Pardee, would yield the "*most favorable outcomes in terms of cost- effectiveness, quality, and access for several reasons*" (Page 96 of Project ID # B-12676-25). Pardee acknowledges that this approach "*may appear to limit traditional competition*," yet contends that consolidation, not competition, is better for patients in Henderson County. This directly contradicts the UNCHW application, which identifies myocardial infarction care (treated through cardiac catheterization) as a key example of why hospital competition is essential.

UNC Health Pardee also advanced a second contradictory argument in its written comments opposing AdventHealth Hendersonville's cardiac catheterization application. There, Pardee dismissed AdventHealth's argument that Henderson County lacks competition, asserting instead that competition must be viewed across a broader regional market, including Mission Health in Buncombe County. Pardee argued that when this broader geography is considered, "*Henderson County residents already have competitive choices for cardiac catheterization services, undermining AdventHealth's core argument*."

Yet UNCHW, like AdventHealth Hendersonville's cardiac catheterization proposal, proposes to serve a multicounty region extending far beyond its home county, including significant projected patient volume from Henderson County. If UNC believes that competition "must consider the broader regional market" when evaluating services for a multi-county service area, then that principle should apply with equal force to its own hospital proposal. Instead, UNCHW selectively narrows its competitive framing to exclude the broader regional context that UNC itself insisted upon in the cardiac catheterization review. UNCHW does not evaluate Mission Health, AdventHealth Hendersonville, or other regional hospitals as part of a single competitive environment, despite UNC's prior statements that such an analysis is required.

Taken together, these inconsistent and self-serving positions undermine the credibility of UNCHW's claimed need for competition. In one application, UNC argues that market concentration is harmful and competition must be introduced. In another, UNC argues that concentration of capacity at a single UNC hospital is beneficial and that existing regional choices already provide adequate competition. UNCHW's current discussion of competition is therefore not supported by its own past statements, nor does it apply UNC's prior competitive logic consistently to its own project.

Given the discussion above, UNCHW fails to demonstrate the need for its project and the expected effects on competition in the proposed service area. The UNCHW application is **non-conforming with Criteria (1), (3), (4), (5), (6), and (18a).**

UNC Health West Misrepresents Facility Revenue & Expenses

In addition to ignoring surplus capacity at UNC Health Pardee, the UNCHW application mischaracterizes major components of the proposed hospital as "non-regulated" or "not part of this project" in order to exclude their utilization, revenue, and full costs from the need and financial analyses. This is inconsistent with the CON law, which regulates capital expenditures for health service facilities, not merely those services the applicant chooses to model in its utilization tables.

UNC proposes four Level III neonatal beds in addition to the 129 beds in the SMFP need determination, but failed to provide projections of revenue and expenses for neonatal inpatient care. Section Q does not include Form F.2b or Form F.3b for neonatal services. These omissions prevent the Agency from evaluating the financial feasibility and operational impact of a reviewable service that requires substantial capital investment, specialized staffing, and ongoing operating resources.

UNC may attempt to claim that neonatal services were incorporated into the inpatient revenue and expense projections; however, the application itself directly contradicts that assertion. On application page 189, UNC states:

> *"UNC Health Pardee's Financial Planning department provided the data used to develop Forms F.2 and F.3 including actual results through the fiscal year ending 06/30/2025 for UNC Health Pardee. Pardee is used for the patient types of all proposed service components. Inpatient Services includes all services provided to an admitted patient including emergency services; Ambulatory Surgical Services includes outpatient OR, outpatient gastrointestinal procedures, outpatient cath procedures and outpatient procedure room patients; Emergency Department includes outpatients only; and, Ambulatory Imaging includes outpatients only to ensure that the financial results do not duplicate revenues or expenses among service components."*

This statement confirms that UNC relied exclusively on UNC Health Pardee's financial data to model all inpatient services. Yet, UNC Health Pardee does not operate any neonatal acute care beds, as reflected in its 2025 License Renewal Application. Because Pardee has no neonatal unit, there is no financial analog on which to base neonatal revenue, expenses, case mix, staffing, or acuity-related costs. Therefore, any assumption that neonatal care can be absorbed into a generalized inpatient financial model cannot be supported.

By failing to submit Form F.2b and Form F.3b for neonatal services, UNC has not accounted for the neonatal unit's impact on facility-level revenue, operating expenses, or working capital needs. These

omissions undermine the accuracy of the application's financial projections and prevent the Agency from evaluating whether the proposed neonatal services, and the hospital as a whole, are financially feasible and compliant with statutory review criteria.

For these reasons, UNCHW is **non-conforming with Criterion (5)**.

Failure to Demonstrate Availability of Working Capital

UNCHW fails to appropriately identify its working capital needs and fails to demonstrate that it has an adequate commitment of funds necessary to pay for its working capital needs.

In its response to Section F.3(c) and (e), UNCHW states that its initial operating period will be five months with initial operating costs at over $12 million and that "*The initial operating period is calculated as the number of months during which cash outflow (operating costs) for the entire facility exceeds cash inflow (revenues) for the entire facility; that period ends for UNC Health West after five months. The initial operating expenses include all non-depreciation expenses, calculated as the difference between the total cash outflow (operating costs) during the initial operating period for the entire facility and total cash inflow (revenues) during the initial operating period for the entire facility*" (pages 106-107).

As shown in its financial statements, UNCHW projects a loss over $36 million in net income and depreciation expenses of over $33 million. Thus, UNCHW projects a net cash loss in its first 12 months of operation. Said another way, UNCHW's cash outflow exceeds cash inflow its entire first 12 months of operation, as shown below, not five months as stated in its application.

UNCHW Net Cash Flow First Full Fiscal Year

	First FY
Net Revenue	$85,324,429
Operating Costs	$121,466,966
Net Income	($36,142,537)
Depreciation-Buildings	$19,896,828
Depreciation-Equipment	$13,617,951
Net Cash Flow	**($2,627,758)**

Source: UNCHW Forms F.2b and F.3b

As such, UNCHW has erroneously stated its initial operating period. Accordingly, it has not reasonably demonstrated that it has accurately calculated its initial operating expenses, nor does it demonstrate an adequate commitment of funds necessary to pay for its working capital needs.

Given the discussion above, UNCHW fails to demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal. The UNCHW application is **non-conforming with Criterion (5).**

Failure to Account for Arden Freestanding Emergency Department

As stated on application page 37, UNCHW proposes to develop an emergency department (ED) with 28 ED bays. However, UNCHW's projections fail to consider recently developed freestanding ED in the identified service area.

UNCHW failed to acknowledge or account for Mission's freestanding ED in Arden (Project I.D. B-012191-22) that opened in November 2024. UNCHW failed to address what impact, if any, the recently developed freestanding ED project will have on its projected ED utilization. Therefore, UNCHW's projected ED utilization is unreliable.

The Agency previously addressed a similar issue in the 2024 Wake County Acute Care Beds and ORs Review, where it found Novant Health Knightdale's application non-conforming with Criterion (3) and others. The Agency determined that NH Knightdale, a proposed community hospital, had failed to account for a recently opened freestanding ED. In its Findings, the Agency stated:

> *There is no indication that the applicant accounted for the WakeMed FSED in Wendell when projecting utilization. The project analyst reviewed Novant's application and exhibits and did not find any mention of the WakeMed FSED in Wendell. Notably, this issue was raised in comments and Novant, in responding to this comment did not cite anywhere in its application or exhibits the WakeMed FSED in Wendell.*
>
> *It is reasonable to deduce that given the location of major traffic corridors, the location of the WakeMed Wendell FSED to the east of the proposed Novant Knightdale emergency department, the map of Novant Knightdale's primary and secondary service areas and the fact that it does not seem reasonable that individuals in need of emergency care would drive past an emergency department to go to an emergency department located farther away the WakeMed Wendell FSED would have a significant impact on projected emergency department visits at Novant Knightdale. Which, in turn, would have a significant negative impact on projected IP discharges at Novant Knightdale given that over 91% of the projected IP discharges at Novant Knightdale are projected to originate from emergency room visits. Therefore, projected IP discharges originating through the emergency department are not reasonably and adequately supported."* [4]

Similarly, UNCHW did not mention Mission's Arden freestanding ED in its application, residents in need of emergency care in UNCHW's service area would have to drive past a Mission emergency department to access UNCHW (see map on application page 156), and 76.8% of the projected inpatient discharges at UNCHW are projected to originate from emergency room visits (see application page 179). As such, the

[4] Accessed at https://info.ncdhhs.gov/dhsr/coneed/decisions/2025/jan/findings/2024%20Wake%20Acute%20Care%20Bed%20and%20OR%20Review%20Findings.pdf

Agency should find UNCHW's projected emergency room and inpatient discharges unreasonable and inadequately supported.

Given the discussion above, UNCHW fails to demonstrate the need for its project and the expected effects on competition in the proposed service area. The UNCHW application is **non-conforming with Criteria (1), (3), (4), (5), (6), and (18a).**

Failure to Demonstrate Reasonable Outpatient Surgery Utilization and Financial Feasibility

In its response to Section C.3, Projected Patient Origin, UNCHW provides the following table demonstrating projected patient origin for its outpatient surgery service component.

Outpatient Surgery	UNC Health West Medical Center*					
	1st Full FY		2nd Full FY		3rd Full FY	
	07/01/2031 to 06/30/2032		07/01/2032 to 06/30/2033		07/01/2033 to 06/30/2034	
County or other geographic area such as ZIP code	Number of Patients **	% of Total	Number of Patients **	% of Total	Number of Patients **	% of Total
Buncombe	2,492	64.2%	4,425	62.7%	7,131	61.8%
Henderson	614	15.8%	1,117	15.8%	1,810	15.7%
Haywood	228	5.9%	437	6.2%	716	6.2%
Transylvania	113	2.9%	216	3.1%	354	3.1%
Madison	45	1.2%	87	1.2%	143	1.2%
Other^	389	10.0%	778	11.0%	1,386	12.0%
Total	**3,880**	**100.0%**	**7,061**	**100.0%**	**11,540**	**100.0%**

* This should match the name provided in Section A, Question 4, and includes mobile health services
** Home health agencies should report the number of unduplicated clients.
^ "Other" includes projected patients from inmigration outside of the PSA and SSA, including ZIP codes in the five counties above, as well as Graham and Yancey counties, other North Carolina counties, and other states.

In its patient origin assumptions, UNCHW states that that "*outpatient surgery includes all outpatient procedure room surgery patients, outpatient GI procedure patients, outpatient minor procedure patients, and outpatient diagnostic and interventional cardiac catheterization procedures*" (page 47). However, as the chart below demonstrates, UNCHW's total outpatient surgery service component volume from its patient origin tables exceeds the aggregated volume projected from each subcomponent.

UNCHW Ambulatory Surgery Service Component Patient Utilization

	First FY	Second FY	Third FY	Notes
OP Procedure Room Surgery Patients	1,552	2,824	4,616	Per page 171
OP GI Procedure Patients	1,025	1,864	3,045	Per page 173
OP Minor Procedure Patients	870	1,583	2,588	Per page 171
OP Diagnostic Cardiac Catheterization Procedures	194	354	578	Per page 175
OP Interventional Cardiac Catheterization Procedures	57	104	169	Per page 175
Total	**3,698**	**6,729**	**10,996**	
Stated Total for Service Component from Patient Origin	3,880	7,061	11,540	
Overstatement	**182**	**332**	**544**	

Consistent with its Patient Origin assumptions, UNCHW states in its Financial Assumptions on page 189 that its Ambulatory Surgical Services includes "*outpatient OR, outpatient gastrointestinal procedures, outpatient cath procedures and outpatient procedure room patients*." UNCHW notes that "*Patient Services Gross Revenue is based on . . . average charge per ambulatory surgery case . . . inflated 3.0 percent annually, and applied to projected patient utilization*." As such, UNCHW's overstated ambulatory/ outpatient surgery service component volumes also result in overstated net revenues for its outpatient surgery service component and overstated revenues for its facility in total.

Given the discussion above, UNCHW fails to demonstrate the need for its project and fails to demonstrate the financial feasibility of the project. The UNCHW application is **non-conforming with Criteria (1), (3), (4), (5), (6), and (18a).**

Comparative Inferiority to the AdventHealth Asheville Application

In evaluating the competing proposals, it becomes clear that the AdventHealth Asheville application is markedly superior to UNC's proposal across every dimension that matters to the State, to the service area, and to the patients who urgently need relief from the region's longstanding lack of hospital competition. AdventHealth offers a faster, more reliable, and more cost-effective path to bringing meaningful competition to Mission Hospital, while UNC's proposal remains largely aspirational, structurally inefficient, and significantly delayed.

1. AdventHealth Provides the Fastest Path to Market, and Competition Cannot Wait

Speed to market is one of the most critical factors in this review. Western North Carolina cannot afford to wait years for the promise of competition. Mission Hospital has recently received its third Immediate Jeopardy citation in the last three years, underscoring the instability and patient safety concerns that continue to impact residents of Buncombe County and surrounding communities. The region desperately needs competition now, not six years from now.

AdventHealth is turn-key ready and can open far sooner than UNCHW. With full site control, extensive infrastructure planning, and construction activities poised to begin as soon as the CON is awarded, AdventHealth is significantly farther along in the development process than any other new hospital applicant. In contrast, much of UNC's proposal reflects future intentions rather than tangible progress. UNCHW's own Form C identifies its first full fiscal year as July 1, 2031 through June 30, 2032, meaning that UNC does not intend to operate the hospital for roughly six years after project approval. What UNC describes is aspirational; what AdventHealth has built is real. AdventHealth is positioned to provide competition to Mission the fastest, which is not only a programmatic advantage, but also a public safety imperative.

2. AdventHealth's Scale Advantage: The Volume–Outcome Relationship

The Volume–Outcome Relationship refers to the well-established principle in healthcare that providers who perform a higher volume of a particular service tend to achieve better patient outcomes. In other words, hospitals and physicians who treat more patients with a specific condition or perform more of a certain procedure generally have:

- Lower complication rates
- Better survival rates
- Fewer readmissions
- Higher overall quality and consistency

This occurs because experience, repetition, specialized staffing, and refined clinical processes all improve performance.

In the context of hospital planning, larger facilities with sufficient patient volume are better able to sustain high-quality specialty services, while smaller, lower-volume hospitals often struggle to achieve the same outcomes.

AdventHealth proposes a 222-bed full-service hospital, a scale that is clinically meaningful and necessary to achieve favorable volume–outcome relationships. A hospital of this size supports the breadth, depth, and acuity required to offer high-quality tertiary services and sustain a robust medical staff.

UNC, by contrast, proposes a facility roughly half that size. The service area does not need two 100-bed hospitals, especially when one of those proposals (UNC) would be duplicating services already operated by UNC Health Pardee, an underutilized hospital with a projected 57-bed surplus. The region needs one strong, competitive alternative to Mission, not two smaller, less efficient facilities.

AdventHealth's scale translates directly into stronger clinical programs, deeper subspecialty coverage, and better patient outcomes.

3. Access for Service Area Residents

UNC Health West's proposal is fundamentally misaligned with the SMFP-defined service area for this review. The SMFP clearly defines the service area as Buncombe, Graham, Madison, and Yancey Counties. Yet the UNCHW application explicitly excludes two of those four counties, Graham and Yancey, from both

its Primary and Secondary Service Areas, effectively omitting 50 percent of the residents in the SMFP-defined service area.

Instead, UNCHW's PSA and SSA are composed almost entirely of ZIP codes in Buncombe and Henderson Counties, with additional ZIP codes in Haywood and Transylvania Counties, counties that already host existing acute care hospitals. Madison County is effectively an afterthought in the UNCHW service area, represented by just one ZIP code and only a minimal presence in its Secondary Service Area.

The area immediately surrounding the proposed Brevard Road site is dominated by three ZIP codes, 28806, 28704, and 28803, that are already among the most urbanized and hospital-proximate areas in western North Carolina, with relatively higher household incomes, higher insurance coverage, and short drive times to existing hospitals in Buncombe and Henderson Counties. Designing a service area around these ZIP codes does little to advance equitable access for rural residents of Madison, Yancey, or Graham Counties who generated the need determination.

This geographic design demonstrates that UNC is prioritizing access for counties outside the SMFP-defined service area, including areas with well-established hospital infrastructure, while excluding SMFP-defined service area communities that lack local acute care hospital access and are among the most vulnerable in the region.

The consequences of this exclusion are reflected in UNC's own projections. In its 3rd project year, UNCHW anticipates:

- 15.7% of its inpatient admissions will come from Henderson County
- 6.2% from Haywood County
- 3.2% from Transylvania County
- Only 1.2% from Madison County
- Virtually no meaningful volume from Graham or Yancey Counties, despite their inclusion in the SMFP service area.

In other words, UNC's proposal would serve patients who already have access to multiple nearby hospitals, while overlooking rural and medically underserved communities who have no acute care hospital at all and who face the longest travel times, poorest health outcomes, and greatest barriers to care.

By contrast, AdventHealth Asheville's proposal is tailored precisely to the SMFP-defined service area and is designed to expand access to the very communities, Graham, Madison, and Yancey Counties, that have been historically marginalized in terms of hospital access. AdventHealth engaged deeply with these communities, conducted extensive outreach, and incorporated their needs directly into service planning.

UNC's selective, exclusionary service area design demonstrates a proposal that is not aligned with State planning principles, not aligned with equitable access goals, and not aligned with the needs of the SMFP-defined service area residents. It prioritizes growth in competitive, already-served markets rather than expanding access to the underserved communities the State intends this project to reach.

4. Geographic Access

UNC Health West's proposed location provides minimal improvement in geographic access for the SMFP-defined service area. The Brevard Road site proposed by UNC is located within Asheville's urban core, less than five miles from Mission Hospital, and remains far more proximate to existing acute care hospitals in Buncombe, Henderson, and Haywood Counties, all of which already have multiple points of hospital access. Locating yet another hospital in this already concentrated corridor does little to expand access for residents of the SMFP-defined service area, particularly those in rural and medically underserved communities. The UNCHW site simply does not fill a geographic gap or reduce travel-time barriers for the counties that generated the SMFP need determination.

By contrast, AdventHealth's conditionally approved Weaverville campus was intentionally chosen to fill a geographic gap in the northern portion of the service area, northern Buncombe, Madison, Yancey, and Graham Counties, areas with well-documented travel-time barriers and limited emergency access. AdventHealth's Weaverville site meaningfully improves access for residents who currently face some of the longest transport times and fewest local healthcare options in the region. The project also aligns precisely with SMFP geographic access principles by placing new acute care capacity in the portion of the service area that is most isolated from existing hospital infrastructure.

AdventHealth's site meaningfully improves geographic access for SMFP-defined service area residents, whereas UNCHW's siting strategy merely adds capacity to a saturated urban corridor without enhancing access for the communities the need determination was intended to support.

AdventHealth is already conditionally approved to develop the first new hospital in Buncombe County in more than a century, a milestone for a county that has not had more than one hospital provider in over 25 years. This introduction of long-absent competition is exactly what the State envisioned when it approved AdventHealth Asheville. The Agency should recognize the importance of this development and exercise caution before authorizing additional acute care projects in parts of Buncombe County that are already well served by existing facilities.

A prudent approach is to allow AdventHealth Asheville the opportunity to carry out the mission the State has already endorsed, to restore meaningful hospital choice, improve access for underserved northern communities, and reintroduce competition to the region. Allowing the county's first new hospital in a century to open and establish its presence before adding yet another acute care provider ensures that State policy goals are advanced rather than diluted by premature proliferation of services in an already well-served corridor.

5. AdventHealth Demonstrated Reliability During Crisis; UNC's Site Did Not

Hurricane Helene provided a real-world stress test for every applicant's proposed capacity, siting decisions, and operational resilience. During the storm, UNC's proposed site lacked access to water, demonstrating a significant vulnerability in emergency conditions, precisely when hospitals must remain fully operational. By contrast, a hospital on AdventHealth's Weaverville site would have maintained access to water and power, with the ability to deliver uninterrupted care and support communities across the region. The Weaverville project improves response times, strengthens emergency preparedness, and builds resilience for future disasters.

6. AdventHealth's Multi-Year Head Start Cannot Be Replicated

AdventHealth has invested years into community engagement, planning, and regulatory preparation for its conditionally approved new acute care hospital. The organization has already secured overwhelming, regionwide support, completed substantial site work, and progressed well into the development cycle. This multi-year head start gives AdventHealth an unmatchable advantage in delivering services quickly.

By comparison, UNC is starting from scratch. Even under optimistic assumptions, UNC cannot open anywhere near as quickly as AdventHealth. Every additional year without competition is another year of compromised access, strained capacity, and patient safety concerns at Mission, a reality the State cannot ignore.

7. AdventHealth Delivers Proven, Reliable Care—Not Hypothetical Capacity

Across every metric, i.e., speed, readiness, scale, resilience, and fiscal responsibility, AdventHealth's proposal is the clear choice. AdventHealth has demonstrated reliability during the region's most challenging moments, invested years in preparing a comprehensive project, and is positioned to bring competition to the service area sooner than any other applicant.

UNC's proposal, in contrast, is years behind, dependent on state funding, located on a site with demonstrated vulnerabilities, and premised on assumptions rather than infrastructure.

For a region in urgent need of competition, stability, and high-quality care, AdventHealth is the superior and only realistic solution.

COMMENTS SPECIFIC TO NOVANT HEALTH ASHEVILLE MEDICAL CENTER (NHAMC) PROJECT ID # B-012709-25

Failure to Demonstrate Need for Proposed Services

Novant's 2025 application relies on a highly constructed and inflationary utilization methodology that fails to produce a reasonable or supported demonstration of need. Although the application repeatedly characterizes its assumptions as "conservative," the underlying methodology is anything but. Instead, Novant strings together a series of aggressive, unvalidated inputs, each of which independently inflates projected utilization, and then relies on the cumulative effect of these assumptions to justify a volume level necessary to support a 34-bed hospital. When examined in detail, however, the projections do not withstand scrutiny.

1. Unrealistic Immediate Shift of Affiliated-Provider Volume With No Ramp-Up

Novant's methodology relies heavily on projected inpatient shifts from its affiliated physician practices. AdventHealth does not dispute that these clinicians may intend to refer appropriate patients to NHAMC if the project is approved. However, Novant's methodological flaw is not the referral estimates, it is the assumption that 100 percent of this projected volume will shift immediately in the very first year of operation.

No new hospital, whether developed by Novant, AdventHealth, Atrium, UNC, or Mission, achieves full projected referral realignment on day one. All new hospitals experience a ramp-up period, during which:

- operational workflows stabilize,
- nursing, surgical, and ancillary staffing reach full maturity,
- clinical programs phase in over time,
- physician confidence in the new facility grows, and
- patients adjust to new access patterns.

Novant provides no evidence that NHAMC will be an exception to this universal operational reality. Instead, the application assumes that the moment the doors open, 75 to 85 percent of all inpatient volume from affiliated practices will instantly redirect to NHAMC, across all specialties and all clinical profiles. There is no ramp-up model, no phasing-in of service lines, no partial-year adjustment, and no historical precedent from other new Novant hospitals demonstrating that such immediate full utilization is realistic.

Moreover, several of the affiliated practices listed in the application have complex patient profiles, oncology, orthopedics, plastics, and women's health, among others. These specialties typically phase into new hospitals gradually as clinical pathways, perioperative protocols, sterile processing, and care-transition systems come online. Novant's assumption of full-volume adoption in Year One disregards these operational and clinical realities.

By failing to model a realistic ramp-up and instead assuming instantaneous full capture of all projected referrals, Novant materially inflates utilization in the early years of the project. The Agency has long required that applicants present reasonable and supported utilization projections. A methodology that

assumes perfect, immediate, and complete referral realignment on opening day does not meet this standard.

For these reasons, even accepting the referral estimates as stated in the physician letters, Novant's assumption of immediate and full-volume shifting is unsound, unsupported, and nonconforming with Criterion (3).

2. Flawed ED Capture Methodology Inflates Utilization

Novant's projections for non-affiliated volume rely on a flawed and overstated ED-capture methodology that lacks statistical accuracy, local relevance, and competitive realism.

A. The 25th-Percentile Claim (36.2%) Is Mathematically Incorrect

Novant's ED-capture methodology materially inflates projected inpatient demand by relying on an incorrect and overstated benchmark for home-ZIP ED market share. Novant asserts that the 25th percentile of all North Carolina hospitals' home-ZIP ED market share is 36.2 percent, and then applies this inflated figure, minus the base year market share for Affiliated Providers, to estimate NH Asheville's ED capture immediately upon opening. However, a proper percentile calculation using the full dataset of 111 hospitals shows that this claim is incorrect.[5]

Using the standard percentile formula:

$$\text{Rank} = 0.25 \times (N + 1)$$

with N = 111, the 25th percentile falls at Rank 28. The actual home-ZIP ED market share at this position, Person Memorial Hospital, is **34.9 percent**, not 36.2 percent. Novant's chosen figure therefore overstates the 25th percentile and artificially inflates NH Asheville's projected ED capture.

Percentile	Formula Position	Rank	Market Share
10th	11.2	Ranks 11–12	≈ 14.6%
25th	28	Rank 28	**34.90%**
50th (Median)	56	Rank 56	54.30%
75th	84	Rank 84	70.70%

Source: Novant Application, Exhibit Q-1 IP ED Market Shares

Novant's miscalculation is not trivial. Even a small inflation in the benchmark significantly increases projected ED volume because the ED capture rate drives the entire pool of non-affiliated inpatient demand. By inserting a value that is 1.3 percentage points higher than the actual 25th percentile, Novant builds its utilization projections on a statistically incorrect and overly aggressive assumption.

[5] For information purposes, Exhibit Q-1 IP ED Market Shares includes 112 hospitals; however, data is provided for 111 hospitals.

Further, real-world comparators within the same region contradict Novant's inflated assumption. AdventHealth Hendersonville, located only 8.9 miles from the proposed NHAMC site and operating as a mature, high-performing hospital, has a home-ZIP ED market share of 18.8 percent, barely half the inflated benchmark Novant claims NH Asheville will achieve on day one. It is simply not credible that a brand-new, 34-bed hospital would capture nearly double the share of an established facility in the same geographic corridor.

B. Failure to Account for Mission's Existing Freestanding ED

Compounding the methodological errors described above, NHAMC fails entirely to acknowledge or account for the substantial impact of Mission Health's existing freestanding emergency department on ED utilization in its home ZIP code.

Mission currently operates an FSED in Arden (Project I.D. B-012191-22) that opened in November 2024. The Arden FSED, located at 2512 Hendersonville Road, shares the same home ZIP as NHAMC and sits just 4.8 miles (approximately 10 minutes) from NHAMC's proposed site. Despite this extremely close proximity and undeniable competitive relevance, NHAMC does not mention the Arden FSED anywhere in its application, much less incorporate its impact into its ED-capture methodology.

This deficiency is not merely an analytical oversight; it is an error that the Agency has already addressed directly in a comparable context. In the 2024 Wake County Acute Care Beds and ORs Review, the Agency found Novant Health Knightdale non-conforming with Criterion 3 because it failed to account for a newly opened WakeMed FSED in Wendell. The Agency's findings in that case could be applied word-for-word to NHAMC:

> *"There is no indication that the applicant accounted for the WakeMed FSED in Wendell when projecting utilization. The project analyst reviewed Novant's application and exhibits and did not find any mention of the WakeMed FSED in Wendell... It is reasonable to deduce… that individuals in need of emergency care would not drive past an emergency department to go to an emergency department located farther away… Therefore, projected IP discharges originating through the emergency department are not reasonably and adequately supported."*

The circumstances in Buncombe County are even more compelling:

- NHAMC shares its home ZIP code with the Mission Arden FSED.
- It is only 4.8 miles from the NHAMC site, far closer than the Knightdale–Wendell comparison in the Wake County case.

Yet NHAMC does not acknowledge the existing Arden FSED, does not adjust its ED-capture assumptions to account for it, and does not address how it will affect ED-originating inpatient demand, despite relying on an ED-driven model in which the vast majority of its projected inpatient discharges originate from the ED, just as in the Knightdale case.

Novant may attempt to argue that its ED-capture methodology is already "conservative" because it relies on the 25th percentile of home-ZIP ED market share. That argument fails for two reasons. First, the 25th percentile is not inherently conservative in a competitive, multi-facility market, especially when the benchmark ignores an existing FSED in the same home ZIP. Second, even a lower-quartile benchmark

becomes artificially inflated and unrealistic when the applicant fails to account for nearer, more established emergency-care access points that will inevitably divert or retain ED volume.

Consistent with the Agency's prior reasoning, NHAMC's failure to model the impact of Mission's Arden FSED renders its projected ED visits, and therefore its projected inpatient discharges, not reasonably and adequately supported under Criterion (3).

In sum, Novant's ED methodology is built on an inflated percentile value, contradicted by local market performance, and blind to existing emergency-care infrastructure. These flawed assumptions materially overstate projected inpatient demand and do not satisfy the Agency's standard for Criterion (3) that projections be rooted in reasonable, credible, and supported methodology.

3. The unexplained 15 percent in-migration factor artificially inflates volume

For non-affiliated inpatient demand, Novant adds a flat 15 percent "in-migration" factor to CAC inpatient days from beyond the three ZIP codes. Given the previous discussion regarding failure to consider Mission's existing and approved FSEDs, this assumption is entirely unsupported. The application identifies no Novant system analogs to justify why 15 percent, rather than five percent or ten percent, should be reasonable.

4. Projected ALOS is implausibly high for a 34-bed community hospital

Novant's Section Q methodology assumes that inpatients admitted to NH Asheville from its affiliated providers will have a weighted average length of stay (ALOS) of 6.29 days. This assumption is extraordinarily high for a small community hospital and is inconsistent with Novant's own operational experience at similarly sized facilities.

Novant currently operates two hospitals in North Carolina that are almost identical in size to the proposed NH Asheville Medical Center, NH Ballantyne Medical Center and NH Mint Hill Medical Center, each with 36 acute care beds. Their actual performance demonstrates that small Novant hospitals do not produce high-acuity, long-stay inpatient profiles:

	NH Ballantyne Medical Center	**NH Mint Hill Medical Center**
Acute Care Beds	36	36
Discharges	1,974	2,937
Days of Care	6,170	8,061
ALOS	**3.1**	**2.7**

Source: 2025 License Renewal Applications

These data show that Novant's similarly configured 36-bed community hospitals operate with ALOS values between 2.7 and 3.1 days, which are less than half of the 6.29 days Novant projects for NH Asheville.

This discrepancy is not a minor calculation variance; it indicates a fundamental inconsistency in Novant's methodology. If Novant truly expects NH Asheville to operate twice the ALOS of its comparable hospitals, it implies that NH Asheville would:

- attract much sicker, higher-acuity patients than NH Ballantyne or NH Mint Hill,
- function more like a tertiary referral hospital than a community facility, and
- require far more ICU capacity, specialty on-call coverage, and clinical infrastructure than the application proposes.

Yet Novant's proposed NH Asheville hospital includes only four ICU beds, limited specialty coverage, and no tertiary service lines. A hospital with a true ALOS of 6.29 days would be more consistent with facilities offering advanced cardiology, neurology, oncology, and surgical capabilities, not a modest, 34-bed community hospital with a narrow scope of services.

The lower ALOS values at NH Ballantyne and NH Mint Hill demonstrate that Novant's 6.29-day assumption is not grounded in operational reality and is therefore not reliable for purposes of determining need.

By assuming an inflated ALOS, Novant artificially increases projected inpatient days, bed need, and occupancy, directly inflating utilization. Consequently, Novant's application does not conform with Criterion (3) because its projections are neither reasonable, credible, nor supported by the applicant's own experience.

Novant may attempt to justify its 6.29-day ALOS by asserting that it is based on "historical" ALOS for patients treated by the affiliated providers whose referrals underpin the project. But any such argument is fundamentally flawed. The affiliated providers do not represent that all of their inpatient volume will shift to NHAMC. In fact, the referral letters contemplate that only clinically appropriate patients will be admitted to NH Asheville, meaning that higher-acuity, longer-stay patients will continue to be admitted to other facilities, not the new 34-bed hospital. Logically, this should reduce, not increase, the expected ALOS for NH Asheville. Novant fails to adjust ALOS downward to account for this reality and instead assumes that every patient type, high-acuity and low-acuity alike, will shift immediately and fully to NH Asheville. This error further inflates the ALOS assumption and renders it inconsistent with both provider intent and real-world patient-sorting behavior.

5. Ancillary and Support Service Projections Are Not Supported

Because NHAMC's projections for inpatient discharges and days of care are overstated and not supported by reasonable assumptions, all dependent service-line projections, including surgery, medical equipment utilization, diagnostic imaging, laboratory, pharmacy, respiratory therapy, and other ancillary departments, are likewise unsupported. These services scale directly with inpatient volume and case mix. When inpatient demand is inflated through unrealistic ramp-up assumptions, an overstated ED capture model, unsubstantiated in-migration, and an implausibly high ALOS, the resulting projections for surgical cases, imaging studies, and ancillary workload become equally unreliable. NHAMC's estimates of procedure room demand, equipment utilization, and support-service staffing and costs therefore rest on the same flawed foundation as its inpatient forecasts and cannot be accepted as credible evidence of need.

Conclusion

Taken together, the deficiencies in Novant's methodology form a consistent and insurmountable pattern of overstatement. Novant assumes an immediate, full-volume shift of affiliated-provider inpatients without any ramp-up; applies an inflated and mathematically incorrect ED-capture benchmark; ignores the undeniable impact of Mission's existing and approved freestanding emergency departments; inserts an unsupported 15 percent in-migration factor; and relies on an implausibly high ALOS that contradicts both Novant's own operational data and the stated referral intentions of its affiliated providers.

Each of these errors independently inflates utilization, but their combined effect produces projections that are disconnected from real-world hospital performance, regional market conditions, and the operational capabilities of the proposed 34-bed facility. Criterion (3) requires applicants to demonstrate need through reasonable, credible, and adequately supported assumptions. Novant's projections do not meet this standard. The application's utilization methodology is structurally unsound, internally inconsistent, and unsupported by empirical evidence. For these reasons, Novant fails to demonstrate need for the proposed services and should be found **non-conforming with Criterion (3)**.

Based on the facts for which NHAMC is non-conforming with Criterion (3), it is also **non-conforming with Criteria (1), (4), (5), (6), (18a), and 10A NCAC 14C .3803.**

<u>Comparative Inferiority to the AdventHealth Asheville Application</u>

In evaluating the competing proposals, AdventHealth Asheville's application is markedly superior to Novant Health's proposal. AdventHealth offers a faster, more reliable, and far more impactful path to bringing meaningful, system-level competition to Mission Hospital, while NHAMC is a small, niche facility with limited scope, distant timelines, and highly speculative utilization assumptions. Where AdventHealth proposes a full-service, 222-bed hospital capable of changing the competitive landscape, NHAMC proposes a 34-bed microhospital that cannot, by design, meet the broader needs of the SMFP-defined service area.

1. Geographic Access: AdventHealth Fills the True Gap; NHAMC Crowds the Already-Served South Asheville

NHAMC proposes to locate its 34-bed hospital at 455 Long Shoals Drive in Arden, less than three miles from the Henderson County line and in immediate proximity to AdventHealth Hendersonville and UNC Pardee. This siting choice does little to improve geographic access for the SMFP-defined service area, because it simply proposes to cluster yet another hospital into a corridor already served by multiple facilities. Residents of Madison and Yancey Counties must travel 45–50 miles and nearly an hour to reach NHAMC's limited services.

By contrast, AdventHealth's Weaverville campus was intentionally selected to close the geographic gap for Graham, Madison, and Yancey County residents, placing a full-service hospital much closer to communities with the longest current transport times. AdventHealth's site redistributes hospital access toward the underserved north and west; NHAMC's site merely duplicates capacity in the already-served south.

Although income levels vary across the Asheville corridor, the ZIP codes surrounding the Long Shoals Road site are among the least Medicaid-dependent areas in Buncombe County. ZIP codes 28803, 28806, 28715, and 28704 have Medicaid coverage rates between 13.8 and 15.0 percent, compared to 21.5 percent countywide. By siting its project in one of the most medically accessible parts of the county, NHAMC does not expand access for medically vulnerable communities in the service area, particularly Madison County, where Medicaid dependence is significantly higher and access barriers are well documented.

Area	% Medicaid
Zip Code 28803	13.8%
Zip Code 28806	13.9%
Zip Code 28715	14.0%
Zip Code 28704*	15.0%
Buncombe County	21.5%
Graham County	15.1%
Madison County	19.0%
Yancey County	12.0%

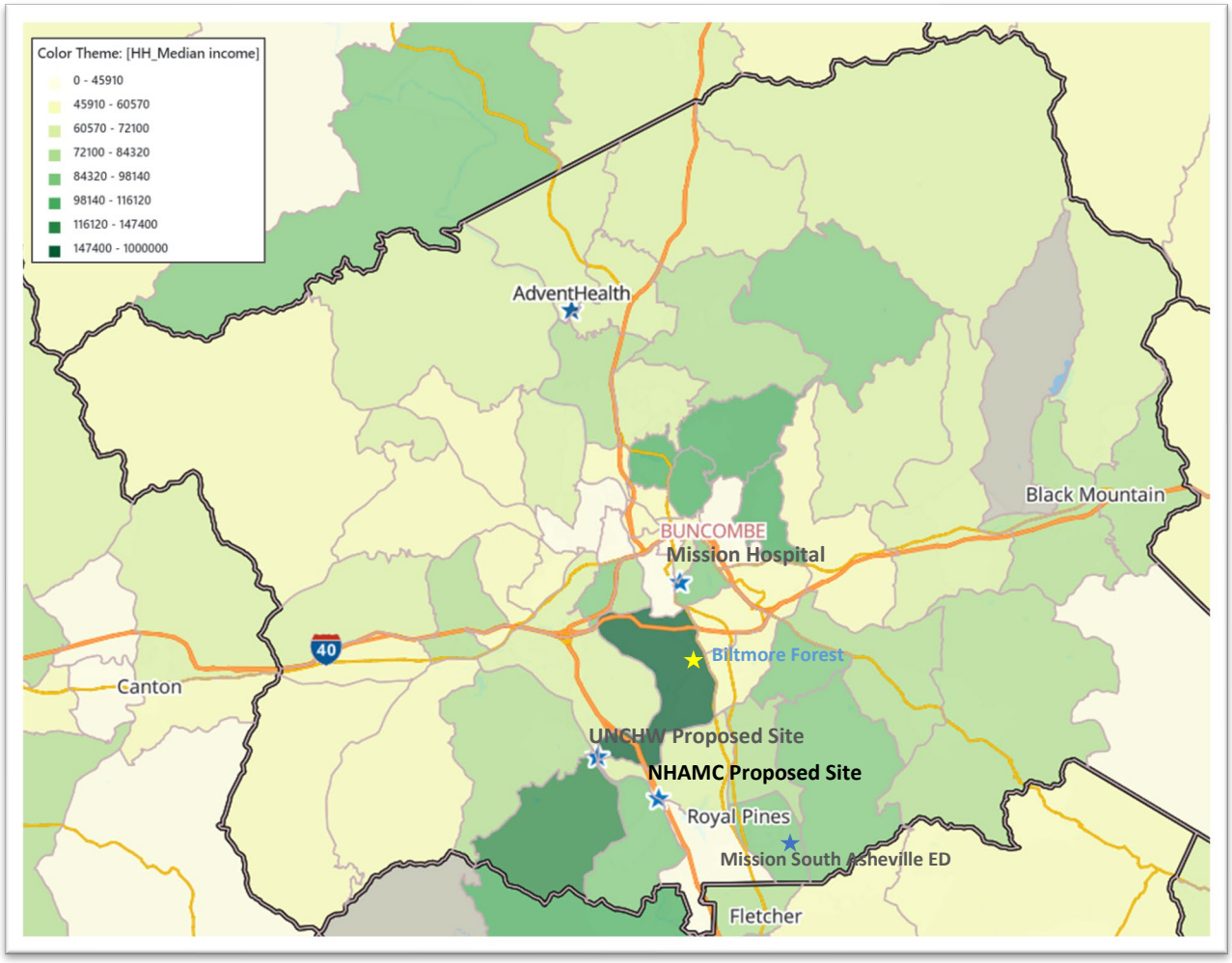
*NHAMC proposed site location
Source: US Census Bureau, American Community Survey, 2023 (data.census.gov)

The proposed NHAMC site sits directly adjacent to Biltmore Forest, identified in independent analyses as the richest municipality in North Carolina, with a median household income of approximately $172,500, more than double the Asheville Metro Area median. [6] ZIP code 28704, where NHAMC intends to build, borders Biltmore Forest.

The following map portrays median household income by census tract and illustrates the fact that the areas immediately adjacent to the proposed site are the most affluent in Buncombe County.

[6] US Census Bureau, American Community Survey, 2023 (censusreporter.org)

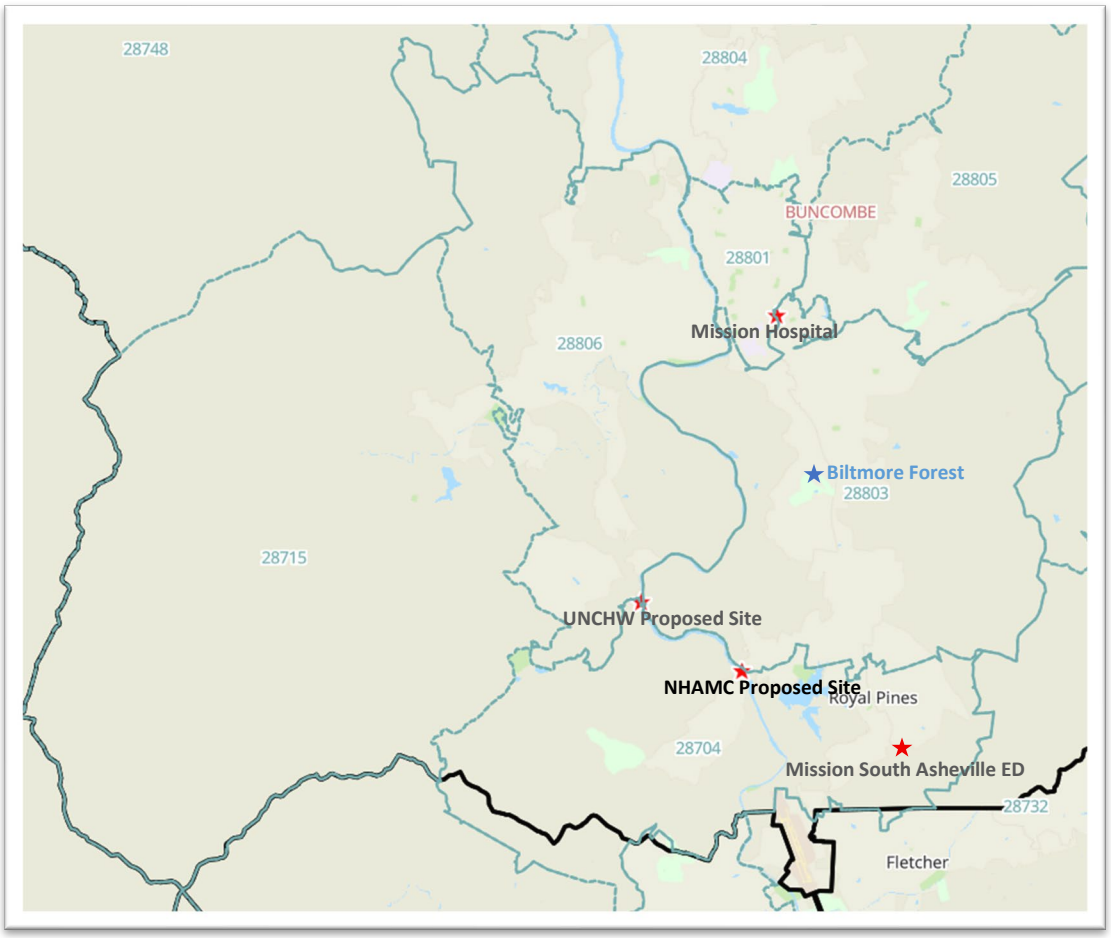
Median Household Income by Census Tract, 2025



Source: Maptitude® mapping software

The Long Shoals Road site is an 11-minute drive from Biltmore Forest. Mission's main ED and its Arden FSED are within 10–12 minutes of Biltmore Forest, underscoring the concentration of existing hospital access already available in this area.

Zip Code Map and NHAMC Proposed Hospital Location



Source: CON applications, Maptitude® mapping software

Given these conditions, NHAMC's siting decision reinforces a simple fact: its project is not designed to expand access for medically underserved communities. Instead, it concentrates new capacity in an area that already benefits from proximity to multiple emergency departments and comparatively low barriers to hospital care.

Meanwhile, residents of Madison, Yancey, and Graham Counties continue to face the longest travel times, the least reliable access, and the greatest need for the scale and acuity that AdventHealth will deliver.

AdventHealth is already conditionally approved to develop the first new hospital in Buncombe County in more than a century, a transformative milestone for a county that has not had two hospital providers in over 25 years. This long-awaited introduction of competition is precisely what the State envisioned when it conditionally approved AdventHealth Asheville. The Agency should acknowledge the significance of this development and exercise caution before authorizing additional projects that would proliferate incremental acute care capacity in parts of Buncombe County that are already well served by existing hospitals.

A prudent approach is to allow AdventHealth Asheville the opportunity to carry out the mission the State has already approved, to restore meaningful hospital choice, improve access in underserved northern portions of the service area, and reintroduce long-absent competition to Buncombe County. Allowing the county's first new hospital in a century to open and establish its presence before adding yet another acute care provider ensures that State policy goals are not undermined by premature proliferation of services in an already well-served corridor.

2. AdventHealth Provides the Fastest and Most Certain Path to Market

Competition is an urgent need, not a long-term aspiration. NHAMC's own timetable shows services beginning January 1, 2030, with construction not completed until mid-2029 and licensure obtained in November 2029. In other words, NHAMC would not provide an alternative to Mission and improve access for the service area for nearly half a decade after this review cycle. AdventHealth, by contrast, already holds two CON approvals, has site control and extensive pre-development work underway, and can move to construction and operations on a materially faster schedule. For a region with only one hospital that is facing repeated Immediate Jeopardy findings and chronic access problems, the choice between a ready-to-build 222-bed full-service hospital and a 34-bed hospital projected to open in 2030 is not a close call. AdventHealth provides the fastest, most certain path to real competition; NHAMC asks patients and the Agency to wait years for a much smaller benefit.

3. AdventHealth's Scale and Scope Advantage Over a 34-Bed, Cancer-Focused Microhospital

NHAMC requests just 34 acute care beds, with only 4 ICU beds and 10 unlicensed observation beds. By design, it is a small hospital anchored in oncology, built around Messino Cancer Centers and a handful of aligned surgical and women's health practices. In terms of both bed scale and service scope, AdventHealth is the only proposal capable of providing a comprehensive alternative to Mission; NHAMC is, at best, a subspecialty satellite that leaves most inpatient needs unaddressed.

4. Access for Service Area Residents: AdventHealth Serves the SMFP Area; NHAMC Serves Its Own Referral Cluster

The SMFP defines the service area as Buncombe, Graham, Madison, and Yancey Counties. NHAMC's methodology and physician alignment strategy center primarily on Buncombe and Henderson County providers and patients, with volume projections drawn overwhelmingly from Mission, AdventHealth Hendersonville, and Pardee. This design naturally favors patients already living in or near the Asheville–Henderson corridor, where multiple hospitals exist today. Residents of Graham, Madison, and Yancey Counties, who currently have no local acute-care hospital, and face long travel times remain largely on the periphery of NHAMC's projected service area and referral base. AdventHealth's conditionally approved Weaverville hospital, by contrast, was intentionally planned around these rural counties and is projected to serve substantially more residents from the SMFP-defined service area than NHAMC, while also providing a full range of acute care services. In practical terms, AdventHealth treats the SMFP service area as the centerpiece of its proposal; NHAMC treats it as an afterthought surrounding a Buncombe–Henderson referral hub.

5. Limited Clinical Capabilities and a Transfer-Dependent Emergency Department

NHAMC describes a 12-room "full-service" ED but simultaneously acknowledges that many higher-acuity patients will require transfer to other hospitals for a higher level of care, using Buncombe County EMS or Novant Critical Care Transport. With only 4 ICU beds and no obstetrics, cardiology, or neurology services, NHAMC's ED will necessarily function as a triage and stabilization point rather than a comprehensive emergency destination. By design, common emergency conditions, STEMI, stroke, obstetrics, heart attacks, will continue to bypass NHAMC or be rapidly transferred elsewhere. A 34-bed, oncology-anchored microhospital cannot provide the breadth of on-call specialty coverage needed to serve as a true regional alternative to Mission. AdventHealth's 222-bed hospital, with robust ICU capacity and specialty programs, is equipped to treat a full spectrum of emergencies on site, not simply hand them off. For service area residents, that difference is the line between a genuine alternative and a way-station.

6. Cost-Effectiveness and Competitive Impact: Too Little Capacity for Too High a Price

The 2025 SMFP identifies a deficit of 129 acute care beds in the service area. NHAMC proposes to address only 34 of those beds, yet must still build an entirely new hospital campus, duplicating fixed costs such as ED, imaging, plant operations, and administrative infrastructure for a very small inpatient platform. This inherently produces a high cost per bed and per patient day. AdventHealth, in contrast, builds on its already-approved 93-bed campus to achieve a clinically meaningful scale of 222 beds, spreading fixed costs across a far larger base of inpatients and service lines. From a system-planning perspective, a 34-bed, cancer-skewed microhospital cannot deliver the same competitive pressure on Mission's 682-bed campus as a full-service, 222-bed AdventHealth hospital. Approving NHAMC instead of, or in addition to, AdventHealth would consume scarce capital and operational resources for comparatively little impact on Mission's entrenched dominance.

7. AdventHealth Is the Only Proposal That Can Function as a True System-Level Alternative to Mission

Across every dimension, timeliness, scale, scope, geographic alignment with the SMFP service area, ED and inpatient capabilities, and the reliability of utilization projections, AdventHealth's proposal is clearly superior to NHAMC's. NHAMC would add a small, oncology-tilted hospital on the already-served southern edge of the market, dependent on aggressive shift assumptions and frequent transfers for higher-acuity care. AdventHealth would deliver a large, full-service hospital in the underserved northern portion of the service area, with the bed capacity, clinical breadth, and geographic positioning necessary to function as a genuine alternative to Mission. For a region that urgently needs robust competition, improved access for rural residents, and a comprehensive response to Mission's quality and capacity issues, NHAMC is simply not enough. AdventHealth is the only proposal in this review that can actually change the trajectory of care in western North Carolina.

COMMENTS SPECIFIC TO MISSION HOSPITAL
PROJECT ID # B-012720-25

Failure to Demonstrate Quality

Pattern of Immediate Jeopardy

Mission Hospital's record is not merely troubling, it is disqualifying. No applicant seeking to expand market share or retain near-total control of a multicounty service area should simultaneously exhibit one of the worst sustained patterns of patient-safety failures in the state. Yet Mission has done exactly that.

Over the last four years, Mission Hospital has been cited for Immediate Jeopardy **five separate times**. These Immediate Jeopardy determinations were not flukes, nor were they triggered by isolated lapses. They stem from more than a dozen separate incidents across multiple years, involving 14 harmed patients, and five patient deaths. Mission has demonstrated a systemic and ongoing inability to provide safe, reliable, and compliant care.

Mission's track record is so severe that, in the context of patient safety, the appropriate analogy is simple:

Three strikes, you're out.

Mission is now on strikes four and five.

Mission Hospital
Pattern of Immediate Jeopardy

	Immediate Jeopardy Effective Date	Date of Event(s) Resulting in IJ	Patients Harmed
	September 25, 2025	July 26, 2025	3
		August 19, 2025	
		September 4, 2025	
		September 16, 2025	
	December 1, 2023	April 5, 2022	9
		July 4, 2022	
		July 5, 2022	
		August 14, 2023	
		October 3, 2023	
		October 17, 2023	
		October 31, 2023	
	December 9, 2023	November 9, 2023	
		November 28, 2023	
	February 19, 2021	February 14, 2021	1
	May 28, 2021	March 1, 2021	1
Total	5	15	14

This is not a system deserving of further trust, further responsibility, or further regulatory deference.

As Mission itself acknowledges in its application, DHSR notified the hospital on October 10, 2025 of an Immediate Jeopardy determination "as of September 25, 2025" involving Governing Body, Patient Rights, Nursing Services, and Emergency Services (p. 155). These are not peripheral issues; they strike at the core of a hospital's ability to protect patients' lives.

By CMS definition, Immediate Jeopardy represents noncompliance so severe that it places patients at risk of serious injury, serious harm, impairment, or death. It is the highest level of regulatory sanction available short of termination from Medicare and Medicaid.

Mission Hospital has reached this level five times since 2021.

Each citation is an indictment, but together they expose a catastrophic breakdown of quality, oversight, and basic patient protection.

2025: A New Immediate Jeopardy, Multiple Incidents, and Another Patient Death

DHSR's 2025 letter makes clear that the Immediate Jeopardy determination was not triggered by one error, but by four separate incidents occurring on:

- July 26, 2025
- August 19, 2025
- September 4, 2025
- September 16, 2025

In total, three patients were found to be harmed, including one patient death.

On July 23, a 72-year-old man (Patient #14) was admitted to Mission Hospital with chest pain and shortness of breath. In the early morning hours of July 26, he was found unresponsive on the floor of his room, disconnected from both his oxygen device and telemetry monitor, and was shortly thereafter pronounced dead.

Surveyors determined that nurses had last checked on the patient at 12:24 a.m., over three hours before he was discovered. During that time, the remote telemetry technician made repeated attempts to alert nursing staff that the patient's telemetry leads had become disconnected, calling at 2:42, 2:44, 3:09, and 3:17 a.m. He escalated to the charge nurse at 3:12 and reached her at 3:26, but she responded that nurses were tied up with a rapid response for another patient and would check on Patient #14 afterward.

A respiratory therapist saw the patient during this period but was unaware of the escalating telemetry alerts and assumed the monitor was meant to be disconnected. At 3:41 a.m., the telemetry tech finally reached a patient care technician, who shortly thereafter discovered Patient #14 unresponsive. A Code Blue was initiated, but no pulse was ever found.

DHSR investigators identified multiple systemic failures, including:

- Telemetry staff did not make an overhead call when unable to reach nurses,
- Nurses failed to follow the hospital's "buddy system" for relaying urgent requests,
- Nursing staff violated protocol by allowing more than two hours between patient checks, and
- The hospital did not ensure adequate staffing levels, noting that telemetry techs monitored up to 45 patients each on 12-hour shifts and nurses carried ratios of five patients per nurse.

Surveyors concluded that Mission Hospital failed to ensure sufficient staff were available to assess and respond to Patient #14, contributing to his death.

In addition, among the patients harmed, DHSR summarized Mission's failures starkly:

- Failure to protect patients from misidentification
- Failure to follow telemetry escalation pathways

- Failure to ensure continuous monitoring during transport
- Failure to respond to patients in emergent distress
- Failure to apply basic infection-control precautions

These are the kinds of failures that destroy trust, jeopardize lives, and demonstrate absolute breakdowns in leadership, systems, and safety culture.

A copy of the CMS Statement of Deficiencies for the September Immediate Jeopardy determination is attached to these comments.

2023: Another Immediate Jeopardy—Nine Deficiencies, 19 Months of Failure

In December 2023, CMS notified Mission that it was not in compliance with the Medicare Conditions of Participation, and that its noncompliance posed immediate jeopardy to patients.

The determination was based on nine deficiencies arising from incidents spanning 19 months, again demonstrating persistent, not episodic, failure. Although CMS later accepted a corrective action plan, the underlying facts remain:

- Multiple patients were harmed.
- Several patients died.
- Mission's systems and oversight were deemed fundamentally unsafe.

Corrective action plans do not erase the pattern, and they certainly do not establish that Mission is capable of safely managing additional service obligations.

Mission's Quality Failures Disqualify It From Expansion

Mission's history shows a documented, repeated, and worsening pattern of patient harm, regulatory failure, and lethal lapses in care. No responsible regulatory body should ignore:

- Five Immediate Jeopardy sanctions
- Five confirmed patient deaths
- 14 patients harmed
- Dozens of system-wide failures across multiple years
- Repeated warnings, unheeded

- And continued deterioration of patient safety

Mission has been given chance after chance.

Three strikes, you're out.

Mission is now on strike five—and counting.

This is not an institution that should be entrusted with further expansion of capacity or consolidation of control over the region's healthcare system.

The fact that it has emerged from this latest Immediate Jeopardy (although it is still not compliant with all conditions of Medicare participation as of the submission of these comments) is irrelevant. There is simply no way that Mission is going to be prevented from seeing Medicare patients as these patients would have to travel at least 2 hours or out of state to receive similar care. Preventing poor patient outcomes is nowhere near the highest priority for those in charge of Mission. Per its parent corporation's own public filings, the bonuses for its executives are based 80% on EBIDTA, with "Complication and Mortality" accounting for only 6%.[7] An inability to further increase EBIDTA by not allowing Mission to expand its services is the only way to incentivize Mission to focus on quality outcomes.

Due to a demonstrated pattern of Immediate Jeopardies based on a failure to provide quality care, Mission should be found **non-conforming to Criterion 20**.

Agency Testimony Regarding Criterion 20

The Agency's own testimony further confirms that Mission cannot be found conforming to Criterion 20. In his deposition, CON Section Team Leader Mike McKillip acknowledged that he did not examine the underlying details of Mission's 2023 Immediate Jeopardy findings because it was "one finding of immediate jeopardy in the review," (even though it was actually two) emphasizing instead that the Agency looks for "a pattern of poor quality care." (emphasis added) When asked how many such incidents would prompt deeper scrutiny, Mr. McKillip responded: **"Probably four would be a lot."** (emphasis added)

Mission does not have four…it has far more.

In 2023 alone, Mission incurred two Immediate Jeopardies, together involving 9 seriously harmed patients, including four patient deaths. And despite these staggering failures, Mission has since accumulated yet another Immediate Jeopardy, the fifth since 2021, based on events occurring on five separate dates. This most recent IJ is not a single lapse but a cluster of individual patient-safety breakdowns across multiple months and departments, further confirming systemic dysfunction.

By the Agency's own metric, Mission has not merely reached the threshold that signals "a pattern of poor quality care," it has far exceeded it**.** Mission has crossed the very line that the CON Section itself identifies as requiring deeper concern, heightened scrutiny, and ultimately a finding of nonconformity under Criterion 20.

[7] https://d18rn0p25nwr6d.cloudfront.net/CIK-0000860730/9ce493b5-10ec-40f3-a667-828c04a2defb.pdf

Public Outcry Is Not "A Boy Crying Wolf" — It Is a Rational Response to Documented Failures

Mission's attempt to dismiss the overwhelming public outcry as exaggerated, emotional, or uninformed could not be more misplaced. The community's reaction is not hysteria. It is not rumor. It is not a "boy crying wolf."

It is the only reasonable response to five Immediate Jeopardies, multiple patient deaths, years of regulatory noncompliance, and independent findings of deteriorating quality, staffing, and safety.

In fact, the public's concerns run parallel to, and are fully validated by, the regulatory actions and independent investigations documenting Mission's decline. Community members are not imagining problems; they are living them.

Mission's independent monitor findings confirm what the community has been saying for years. In mid-2025, the Dogwood Health Trust's independent monitor issued its second consecutive report identifying possible noncompliance with HCA's 2019 purchase agreement, particularly in emergency and oncology services. [8] These are the exact service lines where Mission has repeatedly failed patients, and the same areas at the center of several Immediate Jeopardy citations.

The public outrage did not precede these findings. It matched them.

State officials have reached the same conclusion as the public. The North Carolina Attorney General, now AG Jeff Jackson, continues litigation against HCA over Mission's failure to meet purchase-agreement obligations. [9,10] The AG's office has publicly echoed concerns about ongoing systemic issues at Mission, reinforcing what residents, staff, and patients have been reporting for years.

Meanwhile, multiple antitrust suits filed by local governments against HCA/Mission moved forward after a 2024 federal decision allowed the claims to proceed. These cases settled in August 2025, but the underlying allegations, diminished quality, lack of competition, and harmful market conduct, were never refuted.

Again, the public's concerns were not speculative. They reached the same conclusions.

Academic research further supports community complaints. Wake Forest University's Health Law & Policy Program conducted a rigorous independent analysis and found major staffing cuts at Mission after the acquisition, far deeper than reductions at comparable North Carolina hospitals. These cuts were directly associated with:

- Worsening patient outcomes

[8] Carolina Public Press. (2025, May 28). HCA potentially not in compliance with purchase deal for NC hospital group. Carolina Public Press. https://carolinapublicpress.org/71974/hca-potentially-not-in-compliance-with-purchasedeal-for-nc-hospital-group/

[9] Bonner, L. (2025, August 16). HCA settles antitrust lawsuit with Western NC local governments. North Carolina Health News. https://www.northcarolinahealthnews.org/2025/08/16/hca-settles-antitrust-lawsuit-with-westernnc-local-governments/

[10] Miller, C. (2025, August 19). Attorney General Jackson: NC's HCA Mission Health in 'noncompliance'. Carolina Public Press. https://carolinapublicpress.org/72325/attorney-general-jackson-nc-hca-mission-health-noncompliance/

- Decreased access
- Lower staff morale
- Erosion of quality and safety[11]

This is precisely what patients, nurses, EMS, and physicians have been telling state officials for years. The research confirms the community did not "cry wolf." There really was a wolf…and it was in the hospital.

The unionization of Mission Hospital's nursing staff is one of the clearest indicators that the community's concerns are not exaggerated but grounded in daily clinical reality. Nurses rarely organize unless internal systems for reporting safety risks and staffing failures have broken down. At Mission, the push to unionize was driven by patient-safety fears, chronic understaffing, and repeated warnings to leadership that went unaddressed, the very same issues at the core of Mission's multiple Immediate Jeopardy citations.

When the clinicians closest to patient care conclude that collective action is necessary to protect themselves and those they serve, it is a powerful affirmation that the hospital's problems are systemic, pervasive, and continuing. Mission's nurses have effectively confirmed what regulators, independent monitors, and the public have all said: Mission's quality failures are not isolated incidents. They are a persistent pattern of unsafe care.

Given this comprehensive, multi-source body of evidence, i.e., including multiple Immediate Jeopardies, independent-monitor findings, ongoing AG litigation, federal antitrust actions, academic analyses, declining patient satisfaction, and even the extraordinary step of Mission's nurses unionizing in response to unresolved safety concerns, the conclusion is unmistakable:

The public outcry is not exaggerated. It is overdue.

Mission Hospital has repeatedly failed to provide safe, reliable, and compliant care. The community's reaction is not emotional; it is logical. It is not uninformed; it is aligned with every independent assessment available. And it is not a "boy crying wolf"; it is a public recognizing that, after five Immediate Jeopardies and years of documented failures:

The wolf is real. And Mission put it at the front door of the only hospital in the region.

Conclusion

In light of Mission Hospital's repeated Immediate Jeopardy citations, the sustained pattern of patient harm and regulatory noncompliance, and the unprecedented outcry from patients, frontline clinicians, emergency responders, local governments, and even Mission's own nursing staff, the evidence is unequivocal. This is not a facility that protects patient health and safety, nor one that demonstrates the capacity to correct, much less prevent, systemic failures. The Agency must weigh this documented history

[11] Hall, M. A. (2025, April). HCA/Mission: Changes in patient care following HCA's purchase. Wake Forest University, Health Law and Policy Program. Retrieved from https://prod.wp.cdn.aws.wfu.edu/sites/499/2025/04/HCA-MissionChanges-in-Patient-Care-Following-HCAs-Purchase-working-draft-WFU.pdf

carefully and determine that Mission is **not** in conformity with **Criterion 20**, which requires applicants to demonstrate that quality care has been provided in the past. Mission has repeatedly failed to do so.

Need for Additional Acute Care Beds

Criterion (3) requires an applicant to demonstrate the need the proposed project will meet, using objective and reliable data, and to show that its project is necessary to meet that need. Mission's need demonstration does not satisfy this standard. Mission's arguments rely on legally incorrect interpretations of the SMFP, subjective assertions about competitor capabilities, and data analysis that is contradicted by Mission's own historical utilization. As a result, Mission fails to demonstrate that its project is necessary to meet the needs of the population it serves, as required by Criterion (3).

Misinterpretation of the Acute Care Bed Need Determination

On page 60 of its application Mission states, "*Mission has generated a bed need in the 2022, 2024, and 2025 SMFPs*." Application page 97 states, "*Mission is the only appropriate applicant that can meet the demand for the high acuity services that generated the need*."

To the contrary, the SMFP explicitly states: "Any person can apply to meet the need, not just the health service facility or facilities that generated the need." (2025 SMFP, Chapter 5, p. 47)

The Agency has affirmed this principle. In the 2022 Buncombe/Graham/Madison/Yancey Acute Care Bed Review, the Agency stated:

> "However, anyone may apply to meet the need, not just Mission. Mission has the burden of demonstrating the need for the proposed acute care beds in its application as submitted."

Mission's position would grant the dominant incumbent provider de facto monopoly control over bed determinations. This would directly undermine the purposes of the CON statute, which are to promote competition and ensure that all qualified applicants are evaluated according to merit. Accepting Mission's interpretation would eliminate meaningful competition, discourage efficient capacity management, and effectively nullify the competitive review process.

By relying on an impermissible and unsupported concept of priority, rather than demonstrating a data-driven need for its own project, Mission fails to demonstrate need under Criterion (3). The Agency appropriately rejected Mission's priority arguments in the 2022 and 2024 Buncombe/Graham/ Madison/Yancey reviews and should again do so here.

Unsupported Assertions Regarding Need for High-Acuity Beds

On page 165 Mission asserts that, "*Using the 2025 SMFP need determination to add beds to the undeveloped AdventHealth Asheville-or any other small new hospital applicant-would not resolve Mission's urgent bed shortage, which is driven by high acuity patients currently bottlenecked as they step down from ICU to stepdown and Med/Surg beds. Any new hospital will not be equipped to deliver specialized, high acuity care required by across the service area*." This argument is both misplaced and irrelevant.

First, Criterion (3) evaluates the need for the applicant's own project, not its opinions about competitors. Mission must demonstrate why its beds are needed; it may not negate the need demonstration of another applicant as a substitute for demonstrating its own. Mission's subjective opinions regarding the usefulness of additional beds at AdventHealth Asheville have no bearing on the Agency's evaluation of AdventHealth Asheville's application.

Mission cannot dismiss AdventHealth Asheville's project as inadequate while simultaneously claiming an urgent need for a similar type of capacity and clinical capability AdventHealth proposes. The AdventHealth application is responsive, aligned with community need, and directly supportive of systemwide relief across the service area.

Second, Mission provides no objective evidence that AdventHealth Asheville will lack high-acuity capability. AdventHealth Asheville's proposal is expressly designed to address the very concerns Mission identifies. The Weaverville hospital is planned and scaled to provide higher-acuity, multi-specialty, and tertiary-level services, not a "small" hospital incapable of caring for complex patients. By adding capacity across the acuity spectrum, AdventHealth Asheville will directly relieve Mission's ICU, stepdown and Med/Surg pressures by decanting both high-acuity and routine volume from Mission's campus.

Third, Mission's argument improperly attempts to rewrite the SMFP methodology, which does not distinguish between high- and low-acuity beds. The need determination is for acute care beds, and all qualified applicants may apply to meet that need. Mission's subjective view that only it is capable of addressing high-acuity demand is unsupported by the SMFP, the CON statute, or the evidence in its application.

As such, Mission's high-acuity argument is neither relevant nor credible, and does not satisfy the requirements of Criterion (3).

<u>Mission's Regional-Provider Argument Is Contradicted by Its Own Data</u>

Mission argues that its capacity pressures are driven by its role as a growing "regional provider" attracting patients from outside HSA I. The data do not support this claim.

Mission states on page 68 that its "*role as a regional provider has grown over time based on historical patient origin trends . . This data demonstrates that North Carolina patients from outside of HSA I and the out-of-state patients who are admitted to Mission Hospital have increased at notably higher rates than patients from HSA I".* Following that statement, Mission provides the following excerpted table.

Figure 12
Mission Hospital Growth in Admissions by HSA
2015-2024

Region	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2015 - FFY 2024 % Change
HSA I	36,689	36,891	37,712	38,149	41,317	38,485	39,289	37,329	39,326	42,006	14.5%
HSA II	63	55	63	57	57	71	78	73	89	83	31.7%
HSA III	100	113	93	108	144	146	157	168	189	173	73.0%
HSA IV	50	44	45	51	56	56	84	76	76	97	94.0%
HSA V	37	25	30	47	31	36	53	51	56	49	32.4%
HSA VI	52	46	47	77	70	82	78	49	69	56	7.7%
Out of State	1,096	1,217	1,253	1,231	1,345	1,451	1,753	1,724	1,775	1,896	73.0%
Total	**38,087**	**38,391**	**39,243**	**39,720**	**43,020**	**40,327**	**41,492**	**39,470**	**41,580**	**44,360**	**16.5%**

Source: 2016-2025 Mission Hospital LRAs

While the percentage change statistics for patients outside of HSA I are, in most cases, larger than for HSA I patients, it is clear from the data that the vast majority (95%) of Mission's patients originate from within HSA I and the vast majority of its absolute growth (85%) is attributable to HSA I patients. Further, the vast majority of the absolute, rather than percentage, growth has occurred from patients in HSA I. In fact, as shown below, over 65 percent of Mission's growth from 2015 to 2024 is due to patients from Buncombe County alone.

Mission Hospital Growth in Admissions 2015-2024

	FFY 2015	FFY 2024	Change	% of Total Change
Buncombe County	*17,959*	*22,060*	*4,101*	***65.4%***
HSA I Counties (includes Buncombe)	36,689	42,006	5,317	**84.7%**
Patients Outside of HSA I	1,397	2,354	957	15.3%
Total	38,086	44,360	6,274	100.0%

Source: 2016 and 2025 Mission Hospital LRAs

As shown above, Mission served 957 more patients from outside of HSA I in 2024 than in 2015. If only out-of-area patients contributed to Mission's growth, Mission's ten-year growth would have been just 2.5%, not the 16.5% observed. This demonstrates that local service area patients, not regional tertiary referrals, are the primary drivers of Mission's growth. Because Mission is the only acute care provider in Buncombe County, these patients simply have no other option.

Mission's reliance on a regional-provider argument is unsupported and contradicted by its own data, which fails to conform to Criterion (3).

Mischaracterizations of Capacity Relief and Regional Utilization Trends

Mission states that it "has received no relief" (p.50) while simultaneously appealing the AdventHealth Asheville approval. Mission is therefore preventing the very relief it claims is absent, a circular argument that undermines its credibility.

Application page 51 also indicates that Mission's historical utilization is high enough that it has been approved for a temporary increase in bed capacity.[12] 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.

On page 79 and elsewhere in its application, Mission 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 16.2 percent from FY2019 to FY2024 and patient days grew nearly two times the admission rate at 31.5 percent.

AdventHealth Hendersonville

	FY2019	FY2024	% Change
Admissions	3,288	3,821	16.2%
Days of Care	11,398	14,991	31.5%
ALOS	3.47	3.92	

Source: LRAs

Given the discussion above, Mission does not conform to Criterion (3). Mission fails to demonstrate that its proposed project is necessary to meet the needs of the population it serves. Mission's need narrative relies on incorrect assertions that it holds priority to the SMFP-identified bed need, mischaracterizations of high-acuity demand, and statements that are contradicted by its own utilization data. Mission's arguments improperly focus on disqualifying other applicants rather than demonstrating the need for its own project. As a result, Mission has not provided a credible, objective, or evidence-based demonstration of need.

Therefore, the Mission application is **non-conforming with Criteria (1), (3), (4), (5), (6), (18a), and 10A NCAC 14C .3803.**

Failure to Demonstrate Reasonable Expenses and Revenues

Understated Expenses

Mission's financial statement projections include several errors resulting in a significant understatement of expenses, rendering its financial statements unsupported and unreasonable.

In its Assumptions for Form F.3a and F.3b, Mission states:
"*The following expenses were calculated with 3% expense inflation factor as well as volume variable for additional beds.*

[12] 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.

Contract Services and Independent Contractors including housekeeping and laundry as well as central office overhead and management.
Supplies includes medical supplies, pharmacy supplies, and other supplies.
Implants
Other Operating Expense" (emphasis added, pages 173 and 175).

However, as shown below, Mission's "Other Operating Expense" does not increase at 3% annual inflation after adjusting for increases volume in contradiction to its assumptions and to projected increases for "Contract Services", "Supplies", and "Implants".

Erroneous Annual Increase in Other Operating Expense

	Other Operating Expense	Patient Days	Other Operating Expense per Patient Day	% Change
2024	$1,209,042	216,909	$5.57	
2025	$1,355,154	236,041	$5.74	3.0%
2026	$1,375,331	238,678	$5.76	**0.4%**
2027	$1,395,808	241,345	$5.78	**0.4%**
2028	$1,416,591	244,043	$5.80	**0.4%**
2029	$1,437,682	246,773	$5.83	**0.4%**
2030	$1,459,088	249,533	$5.85	**0.4%**
2031	$1,508,384	247,647	$6.09	4.2%
2032	$1,571,033	250,421	$6.27	3.0%
2033	$1,636,291	253,226	$6.46	3.0%

Source: Mission application pages 172 & 174

This results in tens to hundreds of thousands of dollars in understated expenses annually, as shown in the table below.

Understatement of Other Operating Expense

	Corrected Other Operating Expense per Patient Day	Patient Days	Corrected Other Operating Expense	Stated Other Operating Expense	Understatement of Expenses
2024	$5.57	216,909	$1,209,042	$1,209,042	$0
2025	$5.74	236,041	$1,355,153	$1,355,154	($1)
2026	$5.91	238,678	$1,411,401	$1,375,331	**$36,070**
2027	$6.09	241,345	$1,469,989	$1,395,808	**$74,181**
2028	$6.27	244,043	$1,531,015	$1,416,591	**$114,424**
2029	$6.46	246,773	$1,594,582	$1,437,682	**$156,900**
2030	$6.66	249,533	$1,660,795	$1,459,088	**$201,707**
2031	$6.86	247,647	$1,697,689	$1,508,384	**$189,305**
2032	$7.06	250,421	$1,768,201	$1,571,033	**$197,168**
2033	$7.27	253,226	$1,841,649	$1,636,291	**$205,358**

Similarly, Mission's financial statements also understate other expenses, specifically, "Repairs & Maintenance" and "Rents & Leases". In its Assumptions for Form F.3a and F.3b, Mission states:

"*The following expenses were calculated with 3% expense inflation factor with no volume variable.*
Repairs & Maintenance
Rents & Leases" (emphasis added, pages 173 and 175).

However, as shown below, Mission's "Repairs & Maintenance" and "Rents & Leases" do not increase at 3% annual inflation.

Erroneous Annual Increase in Repairs & Maintenance and Rents & Leases

	Repairs & Maintenance	% Change	Rents & Leases	% Change
2024	$7,067,336		2,138,218	
2025	$7,279,356	3.0%	2,202,365	3.0%
2026	$7,387,740	**1.5%**	2,235,156	**1.5%**
2027	$7,497,737	**1.5%**	2,268,435	**1.5%**
2028	$7,609,372	**1.5%**	2,302,211	**1.5%**
2029	$7,722,669	**1.5%**	2,336,489	**1.5%**
2030	$7,837,653	**1.5%**	2,371,277	**1.5%**
2031	$7,497,737	**-4.3%**	2,268,435	**-4.3%**
2032	$7,722,669	3.0%	2,336,489	3.0%
2033	$7,954,349	3.0%	2,406,583	3.0%

This results in hundreds of thousands to millions of dollars in understated expenses annually, as shown in the table below.

Understatement of Repairs & Maintenance and Rents & Leases

	Corrected Repairs & Maintenance	Stated Repairs & Maintenance	Corrected Rents & Leases	Stated Rents & Leases	Combined Understatement
2024	$7,067,336	$7,067,336	$2,138,218	$2,138,218	$0
2025	$7,279,356	$7,279,356	$2,202,365	$2,202,365	($0)
2026	$7,497,737	$7,387,740	$2,268,435	$2,235,156	**$143,276**
2027	$7,722,669	$7,497,737	$2,336,489	$2,268,435	**$292,985**
2028	$7,954,349	$7,609,372	$2,406,583	$2,302,211	**$449,349**
2029	$8,192,979	$7,722,669	$2,478,781	$2,336,489	**$612,602**
2030	$8,438,769	$7,837,653	$2,553,144	$2,371,277	**$782,983**
2031	$8,691,932	$7,497,737	$2,629,738	$2,268,435	**$1,555,498**
2032	$8,952,690	$7,722,669	$2,708,631	$2,336,489	**$1,602,162**
2033	$9,221,270	$7,954,349	$2,789,890	$2,406,583	**$1,650,228**

Given the discussion above, Mission fails to demonstrate the financial feasibility of the project. The Mission application is **non-conforming with Criterion (5).**

Failure to Demonstrate Positive Effects on Competition

Control of Acute Care Beds in Service Area

Mission Hospital currently controls 100 percent of the licensed acute care beds in the service area. Mission's proposal to add another 129 acute care beds would extend and entrench its dominance in Western North Carolina's hospital market, precisely the type of market concentration that Criterion (18a) was enacted to prevent.

AdventHealth Asheville, by contrast, is the only applicant positioned to bring meaningful competition to Buncombe County. AdventHealth Asheville is conditionally approved to develop 93 acute care beds (Project I.D. B-12233-22 and B-12526-24), but Mission has appealed both approvals, delaying any competitive relief to the region.

If Mission's application is approved, Mission will control 90.3 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 and developed, AdventHealth Asheville will control 23.2 percent of the existing and approved acute care beds in the Buncombe/Graham/Madison/Yancey multicounty service area.

Put simply: Mission's project increases market dominance. AdventHealth's project reduces it.

With regard to patient access and competitive choice, AdventHealth Asheville's project is indisputably the more effective alternative, and Mission's is the less effective alternative under Criterion (18a).

Mission's History Demonstrates the Risks of Market Control

Independent investigations, state regulatory findings, and federal enforcement actions consistently document severe quality-of-care and governance concerns at Mission. These findings are not speculative, they are well-documented, repeated, and worsening, and they are exactly the harms associated with an unrestrained single-hospital system.

Most notably, Mission has been placed in "immediate jeopardy" by the U.S. Centers for Medicare & Medicaid Services three times since December 2023, and five times since 2019. Immediate Jeopardy is CMS's most severe sanction, issued only when a hospital's failures place patients at risk of serious harm or death. No other hospital in North Carolina has a record approaching this frequency.

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

Mission's repeated failure to maintain patient safety standards demonstrates that it cannot credibly claim that its expansion would have a positive impact on quality. Because Criterion (18a) requires positive effects on competition and quality, Mission's failure on Criterion (20) also renders it non-conforming to Criterion (18a).

Widespread Public and Professional Alarm About Mission's Governance

In a historic development underscoring the community's distress, a broad coalition of elected officials, physicians, nurses, patient advocates, and community leaders has formed Reclaim Health WNC (https://reclaimhealthcarewnc.org/), a volunteer-led organization committed to unwavering support for staff at Mission Health and holding HCA accountable through the empowerment of our community. The group includes:

- Physicians (Messino, Lalor, Kline)
- Nurses and frontline clinicians
- Multiple mayors (Brevard, Highlands)
- Community leaders and patient advocates
- State Senator Julie Mayfield
- Former leaders of the Western Carolina Medical Society

The group's stated goals include:

- Replacing HCA with a nonprofit owner that will prioritize patient care,
- Holding HCA accountable for its harmful practices, and
- Restoring safe, high-quality care for Western North Carolina.

This level of collective concern from clinicians, elected officials, and community organizations is unprecedented in North Carolina and highlights the systemic dysfunction that has arisen in a market where Mission faces no meaningful competition.

Based on this publicly available information, it could not be more evident that Mission's proposal to expand its licensed bed capacity to include 129 additional acute care beds cannot positively impact competition in the service area. Mission's application should be found **non-conforming with Criterion (18a).**

Comparative Inferiority to the AdventHealth Asheville Application

AdventHealth Asheville is decisively superior to Mission Hospital's application across every fundamental comparative factor. Mission's proposal suffers from deep structural deficiencies, unresolved quality-of-care failures, misalignment with service area needs, and a lack of community trust that cannot be corrected with additional acute care beds. By contrast, AdventHealth offers a transformational, community-driven, and fully ready solution that directly addresses the urgent need for scale, competition, access, and quality in the SMFP-defined service area.

1. AdventHealth Represents the Only Path to *New* Competition; Mission Reinforces an Entrenched Monopoly

Mission has operated as the sole hospital provider in Buncombe County since 1995, currently controlling the entire acute care capacity within the SMFP-defined service area. Its application merely preserves this control. Mission's proposal cannot enhance competition because *it is the incumbent monopolist*. Additional beds under Mission's control perpetuate the same market dynamics, referral patterns, and quality failures that have plagued the region for years.

AdventHealth is the only applicant proposing a full-service, system-scale, independent alternative capable of challenging Mission's dominance. Mission's application would deepen rather than alleviate the competitive imbalance that prompted this need determination.

In competitive reviews, the Agency consistently identifies the application that increases competition as the more effective alternative. Mission's application, by definition, cannot satisfy this factor.

2. AdventHealth Is Fully Conforming; Mission Is Not, and Cannot Be Approved

Mission fails to conform with multiple statutory and regulatory review criteria, most notably Criterion 20 (Quality of Care), but also Criterion 3, Criterion 5, and Criterion 18a.

Mission's repeated Immediate Jeopardy determinations, documented patient harm, deficiencies in emergency care, staff complaints, and ongoing federal and state investigations demonstrate a system that is not providing safe or effective care, and is therefore ineligible for approval under Criterion 20.

In stark contrast, AdventHealth is the only applicant that fully conforms to all Criteria in this competitive review. A nonconforming application cannot be approved, which makes AdventHealth not only the superior alternative, but the only approvable alternative.

3. AdventHealth's Geographic Access Advantages Are Dramatic; Mission's Proposal Leaves Rural Counties Behind

The SMFP-defined service area consists of Buncombe, Graham, Madison, and Yancey Counties. Mission's proposed beds are located in the same place all Mission beds already exist, central Asheville, the area of the service area with the shortest travel times and densest hospital infrastructure.

The Mission site provides no new access to rural or geographically isolated communities. Graham, Madison, and Yancey Counties, whose travel-time barriers motivated this need determination, remain great distances from Mission's campus.

AdventHealth's conditionally approved Weaverville hospital, by contrast, was intentionally chosen to expand access to:

- Northern Buncombe
- Madison County
- Yancey County
- Graham County

AdventHealth provides the only proposal that meaningfully reduces travel time and improves emergency access for the people the SMFP explicitly identified as underserved.

Mission's location further concentrates beds in an already saturated corridor; AdventHealth's extends acute care to communities with the highest need.

4. Quality of Care: AdventHealth Offers Stability; Mission's Record Demonstrates Repeated, Systemic Failure

Mission's quality problems are severe, persistent, and well-documented. As presented in AdventHealth's Criterion 20 comments:

- Mission has incurred five Immediate Jeopardy determinations since 2021, including:
  - Harm to more than 20 patients
  - Five patient deaths
  - IJ findings based on multiple dates and multiple departments
- CMS, DHSR, Dogwood Health Trust, the NC Attorney General, Wake Forest University researchers, and national media have all documented Mission's:
  - Staffing collapses
  - ED failures
  - Delays in time-sensitive care
  - Patient identification and monitoring failures
  - Infection prevention lapses
  - Plummeting patient satisfaction
  - Chronic safety deficiencies

Mission also holds a B Leapfrog rating and recently received 1 star in HCAHPS patient recommendations, placing it in the lowest 3.6% of hospitals nationwide.

AdventHealth Hendersonville, by contrast:

- Has maintained an A Leapfrog Safety Grade
- Holds a 5-star CMS Overall Rating
- Provides consistently strong patient satisfaction
- Has no Immediate Jeopardy notices in recent years

The contrast between the two organizations' quality profiles is stark and unequivocal. Approving Mission's application would reinforce a system with an ongoing pattern of harm, while AdventHealth provides a stable, high-performing alternative.

5. Community Support Is Unanimous for AdventHealth; Mission Has Lost Trust Across the Region

Mission's application is not supported by the people of the SMFP-defined service area. Public comments, sworn testimony, unionization efforts, and years of community outcry all reflect a deep erosion of trust in Mission's ability to provide safe, timely, and patient-centered care.

AdventHealth, by contrast, has secured:

- Over 100 written endorsements
- 5,000+ community letters of support
- Support from all four county commissions, all four sheriffs, all four EMS agencies, all four health departments, all public school systems, and dozens of municipalities, FQHCs, and non-profits
- Endorsements from fire chiefs' associations representing every fire department in Buncombe, Madison, and Yancey Counties
- Support from eight members of the General Assembly

Community support is not a tie-breaker, here, it is a referendum. The people who live in the service area overwhelmingly support AdventHealth, not Mission. Their perspective is informed by lived experience and should be given great weight.

6. AdventHealth Offers a Faster and More Reliable Path to System-Level Improvement

AdventHealth's Weaverville hospital is already conditionally approved and can immediately begin development once it receives its CON. Mission's application does nothing to change the region's healthcare landscape, it simply requests more beds at an underperforming, overcrowded, and deeply troubled facility.

Mission has not shown that additional beds at its existing campus will resolve its:

- Repeated safety failures
- ED delays
- Staffing shortages
- Inpatient flow breakdowns

AdventHealth provides new leadership, new culture, new infrastructure, and new competition, all of which are essential for transforming healthcare quality in Western North Carolina.

Conclusion

Across every comparative factor, competition, access, quality, scale, cost-effectiveness, readiness, and community support, AdventHealth Asheville is overwhelmingly superior to Mission Hospital's proposal.

Mission's application:

- Reinforces an entrenched monopoly
- Does not enhance geographic access
- Is unsupported by the community at large
- Does not solve the root causes of Mission's ongoing safety and quality crises

AdventHealth's proposal:

- Provides immediate, full-service, system-level competition
- Reduces travel times for underserved counties
- Aligns directly with the SMFP service area
- Brings a 222-bed hospital with high-performing clinical programs
- Is fully conforming and fully supported by the region

For a service area in urgent need of expanded capacity, improved quality, and meaningful competition, AdventHealth is the only effective alternative.

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

Four 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 129 acute care beds. Based on the 2025 SMFP's need determination, only 129 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-012720-25	No
AdventHealth Asheville	B-012716-25	**Yes**
Novant Health Asheville Medical Center	B-012709-25	No
UNC Heath West	B-012708-25	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)

Competition is one of the most consequential comparative factors in this review. In previous competitive batch reviews, the Agency has recognized that "generally, the application proposing to increase competition in the service area is the more effective alternative regarding this comparative factor." That principle, while accurate, does not fully capture the weight and urgency of the competitive deficiencies that define the acute care landscape in 2025 acute care bed review.

For nearly thirty years, Mission Hospital has operated as the sole hospital provider in Buncombe County. Since the sale of the not-for-profit Mission Health System to HCA Healthcare in 2019, the region's only hospital has been operated by a national, for-profit corporation without state oversight over its rates, physician employment, service closures, or contracting practices. Over this period, Mission has accumulated an extensive record of regulatory, operational, and quality-of-care concerns, each of which underscores the danger of a single-provider market and the urgent need for a full-service alternative.

Following HCA's acquisition, the region has experienced destabilization of local healthcare infrastructure, including clinic closures, provider departures, repeated nurse-led public demonstrations over unsafe staffing, and well-publicized allegations of anti-competitive conduct. Multiple legal actions, including class-action lawsuits filed by patients, municipalities, and employers, allege unlawful maintenance and enhancement of monopoly power, artificially high prices, reduced access, and declining quality.

These community concerns have been compounded by repeated and severe regulatory findings. Mission Hospital was cited for multiple Immediate Jeopardy events between 2021 and 2023 related to profound failures in emergency care, triage, assessment, monitoring, and staffing. CMS investigators concluded that Mission's actions "placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death."

In 2025, Mission received an additional Immediate Jeopardy citation, triggered by three separate safety incidents occurring between July and September 2025, further evidence that the underlying issues are systemic, persistent, and incompatible with a single-hospital market.

The cumulative effect of these events is unmistakable: Mission Hospital's dominant control of the service area's acute care beds has directly contributed to declining quality, unstable operations, insufficient oversight, and unacceptable risks to patients. A proposal that would expand Mission's dominant market position by adding 129 additional beds cannot be an effective alternative under this comparative factor.

Assessment of the Competing Proposals

Against this backdrop, the Agency must determine which proposal most effectively establishes meaningful patient access to a new or alternative provider. Only an applicant capable of operating a full-service,

clinically robust, and sufficiently scaled hospital can reasonably be expected to counterbalance Mission's entrenched market power and restore patient choice.

UNC Health West

UNC Health West proposes a new hospital located in south Asheville, one of the most heavily developed, highest-access areas of Buncombe County, within only a few miles of Mission Hospital and surrounded by multiple existing hospitals in Buncombe, Henderson, and Haywood Counties.

UNCHW's proposed location provides minimal improvement in geographic access for the SMFP-defined service area. Its site is not situated in any underserved or travel-burdened area of the region. As discussed in this application, the communities most disadvantaged by the current monopoly, particularly in Madison, Yancey, and Graham Counties, would not experience measurable improvements in access as a result of UNCHW's location.

In addition, the UNCHW proposal is structurally complex and significantly delayed. The proposed facility includes an ambitious, vertically dense, 7-story tower with a large slate of specialty beds (including LDRP, Level III neonatal, and psychiatric beds) that will require a multiyear construction schedule, additional regulatory approvals, and substantial workforce expansion prior to opening. Under the most realistic construction timelines, UNCHW is unlikely to bring capacity online quickly enough to meaningfully address the acute access deficiencies in the near term.

Finally, while UNC Health is a reputable academic system, its Asheville proposal lacks the demonstrated community alignment and endorsement necessary to serve as the region's trusted alternative provider.

The scale and scope of its outreach fall far short of the comprehensive, region-wide engagement undertaken by AdventHealth. The absence of broad local support in a region that has been intensely vocal about its healthcare challenges is a critical comparative weakness under this factor.

For these reasons, UNCHW does not represent the most effective competitive alternative in this review.

Novant Health Asheville Medical Center

The NHAMC proposal envisions a small-scale 34-bed micro-hospital. While well-intentioned, such a facility cannot function as a meaningful alternative provider or materially influence market competition. A 34-bed micro-hospital lacks the capacity, service complement, clinical depth, staffing structure, and economies of scale required to address the systemic competitive deficiencies in the region.

Such a facility cannot:

- Absorb substantial patient demand during peak periods
- Support a comprehensive range of specialty services
- Provide tertiary-level care that first responders and physicians require
- Compete operationally with a 700+ bed monopoly hospital
- Establish the clinical credibility required to change patient referral patterns
- Function as a competitive counterweight in contracting and pricing dynamics

As a result, NHAMC does not meaningfully increase competition in the service area.

AdventHealth Asheville

AdventHealth Asheville is the only applicant offering a full-service, appropriately scaled, operationally credible alternative capable of restoring competition in the service area.

AdventHealth is positioned to operate a comprehensive acute care hospital with broad emergency, surgical, diagnostic, inpatient, and specialty capacity. The proposed 129 beds are integral to establishing a clinically robust alternative that can safely and effectively serve patients across all acuity levels.

AdventHealth's proposal is uniquely grounded in an extensive, multi-year regional engagement initiative unmatched by any other applicant. AdventHealth has secured more than 100 endorsements from local governments, EMS agencies, sheriffs, school systems, health departments, FQHCs, educational institutions, community nonprofits, and physicians across all 18 counties of Western North Carolina. The organization collected 5,000 plus letters of community support, traveled more than 11,000 miles, visited every municipality and zip code in the service area, and hosted more than 50 listening sessions with the communities described in the CON statute.

Residents consistently cited emergency care delays, long waits for appointments, diminishing service availability, and deteriorating experiences at the region's only hospital. Rural communities emphasized the burden of travel times. First responders stressed the danger of relying on a single hospital for trauma and medical emergencies. FQHCs highlighted the need for reliable specialist access and timely diagnostics.

These needs, and the clear call for a full-service alternative, are at the center of this application. The regional consensus is unmistakable: the people of Buncombe, Graham, Madison, and Yancey Counties want a hospital with the scale, services, and capability necessary to restore meaningful competition. AdventHealth Asheville is the only proposal that meets this standard.

Conclusion

For all the reasons described above, AdventHealth Asheville is clearly the most effective alternative under the comparative factor Competition (Patient Access to a New or Alternative Provider). Its proposal introduces a full-service, clinically robust, community-aligned alternative to Mission Hospital's longstanding monopoly, supported by an unprecedented level of regional engagement and endorsement. Neither UNCHW nor NHAMC offers the scale, geographic reach, service mix, community trust, or operational readiness necessary to restore meaningful hospital competition in the Buncombe/Graham/Madison/Yancey multicounty service area.

AdventHealth Asheville's proposal is therefore the most effective alternative with respect to improving patient access to a new or alternative provider in this review.

Scope of Services

The scope of services proposed by the four applicants varies substantially in breadth, acuity, and operational capability. Under this comparative factor, the Agency has historically determined that the application proposing to offer the most comprehensive range of necessary and appropriate acute care

services is the more effective alternative for meeting the identified need. Applications that fail to provide a broad service complement, tertiary capacity, or an appropriate platform of support services are less effective alternatives.

A meaningful comparison of the four proposals demonstrates that AdventHealth Asheville offers the most complete, patient-centered, and clinically robust scope of services, while the other applications provide narrower or more limited service arrays that restrict their ability to meet community needs.

AdventHealth Asheville: A Comprehensive, Full-Service Acute Care Hospital

AdventHealth Asheville proposes a full-service, 222-bed acute care hospital with a broad range of inpatient, diagnostic, emergency, and surgical services designed to function as a complete alternative to Mission Hospital. The proposed scope includes:

- 24/7 Emergency Department with 28 treatment spaces
- Comprehensive surgical services (inpatient & outpatient)
- General medical, surgical, and telemetry beds
- Critical care services (32 ICU beds)
- Full diagnostic imaging platform, including CT, MRI, ultrasound, and nuclear medicine
- Cardiology, oncology, orthopedics, gastroenterology, women's services, and other key specialties
- Laboratory services, pharmacy, respiratory therapy, and allied health support
- Integration with AdventHealth's regional network, including specialty clinics and post-acute care

AdventHealth Asheville's services were developed after extensive community engagement and reflect the needs of rural and underserved populations in Buncombe, Graham, Madison, and Yancey Counties. The proposal provides the only truly complete service array among the competing applicants, enabling the hospital to care for patients across all acuity levels and reduce the region's dependence on Mission Hospital.

Mission Health: Expanded Capacity within an Existing Controlling Platform

Mission Health proposes adding 129 acute care beds to its existing hospital. While Mission offers a broad range of services by virtue of its legacy facility, its proposal does not expand scope, it simply enlarges the capacity of a single existing provider.
Importantly, Mission's application:

- Does not introduce new services
- Does not address gaps in access for rural counties
- Does not correct the region's lack of provider choice
- Reinforces the existing monopoly by expanding the services available only at Mission

Because Mission is already the sole provider of high-acuity inpatient and tertiary services in the region, the proposed expansion does not improve the diversity or geographic distribution of services. Instead, it increases the volume of services available at the very institution whose safety, quality, and access deficiencies have been extensively documented.

Under this comparative factor, Mission's proposal does not increase the *scope* of services available to the region, only the quantity delivered by the same monopoly provider.

UNC Health West: A Broad but Strategically Misaligned Scope of Services

UNC Health West proposes a service mix that appears broad on paper, including Level III neonatal beds, psychiatric beds, and acute care beds, but the scope is misaligned with the SMFP-defined service area, the identified need, and the State's geographic access principles.

The need determination is for general acute care beds. UNCHW's scope places emphasis on Level III neonatal acute care beds and inpatient psychiatric beds. These units add major construction, staffing, and regulatory complexity. They do not meaningfully improve access to general acute care beds in the four-county SMFP service area, and their inclusion delays project readiness without addressing the core identified acute care bed need.

Moreover, the SMFP service area includes Buncombe, Graham, Madison, and Yancey Counties. UNC explicitly excludes Graham and Yancey Counties from both its Primary and Secondary Service Areas. Madison County appears only as a single ZIP code. Meanwhile, UNC captures large portions of Henderson, Haywood County, and Transylvania County, counties that already have acute care hospitals and are *not* part of the SMFP-defined service area.

UNC's own projections show:

- 15.7% of admissions from Henderson
- 6.2% from Haywood
- 3.2% from Transylvania
- 1.2% from Madison
- Virtually zero from Graham and Yancey

UNC's service mix and scope therefore serve areas *outside* the SMFP need while excluding or marginalizing the very communities for whom the need was established.

UNC's proposal also duplicates services already offered by UNC Health Pardee, which is projected to have a 57-bed surplus. The region does not need two competing mid-sized UNC hospitals. It needs one strong, full-service alternative to Mission.

In summary, UNC's scope is not aligned with the purpose of this review. Under this comparative factor, UNC's scope is broad but strategically ineffective.

NHAMC: Limited Micro-Hospital Service Offerings

The NHAMC proposal includes a 34-bed micro-hospital offering a narrow service scope appropriate for a small community hospital but insufficient to serve as a regional provider. Its services include:

- Limited medical/surgical inpatient capacity
- Very limited specialty coverage
- No neonatal care or labor and delivery services

- No critical care capacity
- No cardiac, oncology, or advanced surgical capabilities
- Diagnostic imaging appropriate only for low-to-moderate acuity patients

The micro-hospital model is not capable of supporting the acuity, complexity, or volume of patients in the four-county service area. This narrow scope significantly limits its ability to function as:

- A destination for emergency transports
- A referral option for specialty care
- A provider of advanced diagnostic and surgical services
- A competitive alternative to Mission Hospital

Under this comparative factor, NHAMC offers the least comprehensive service array.

Conclusion: AdventHealth Asheville Provides the Most Effective Scope of Services

Of the four applicants, AdventHealth Asheville is the only proposal offering a full-service, appropriately scaled acute care hospital capable of addressing:

- The region's documented access deficits
- The need for a clinically credible alternative to Mission
- The service gaps identified by rural residents
- The need for comprehensive emergency, surgical, and inpatient capabilities
- The demand for specialty access and diagnostic services

Mission expands capacity without expanding scope. UNC Health West expands scope without aligning to the region's most pressing needs. NHAMC offers a scope too limited to alter the region's healthcare landscape.

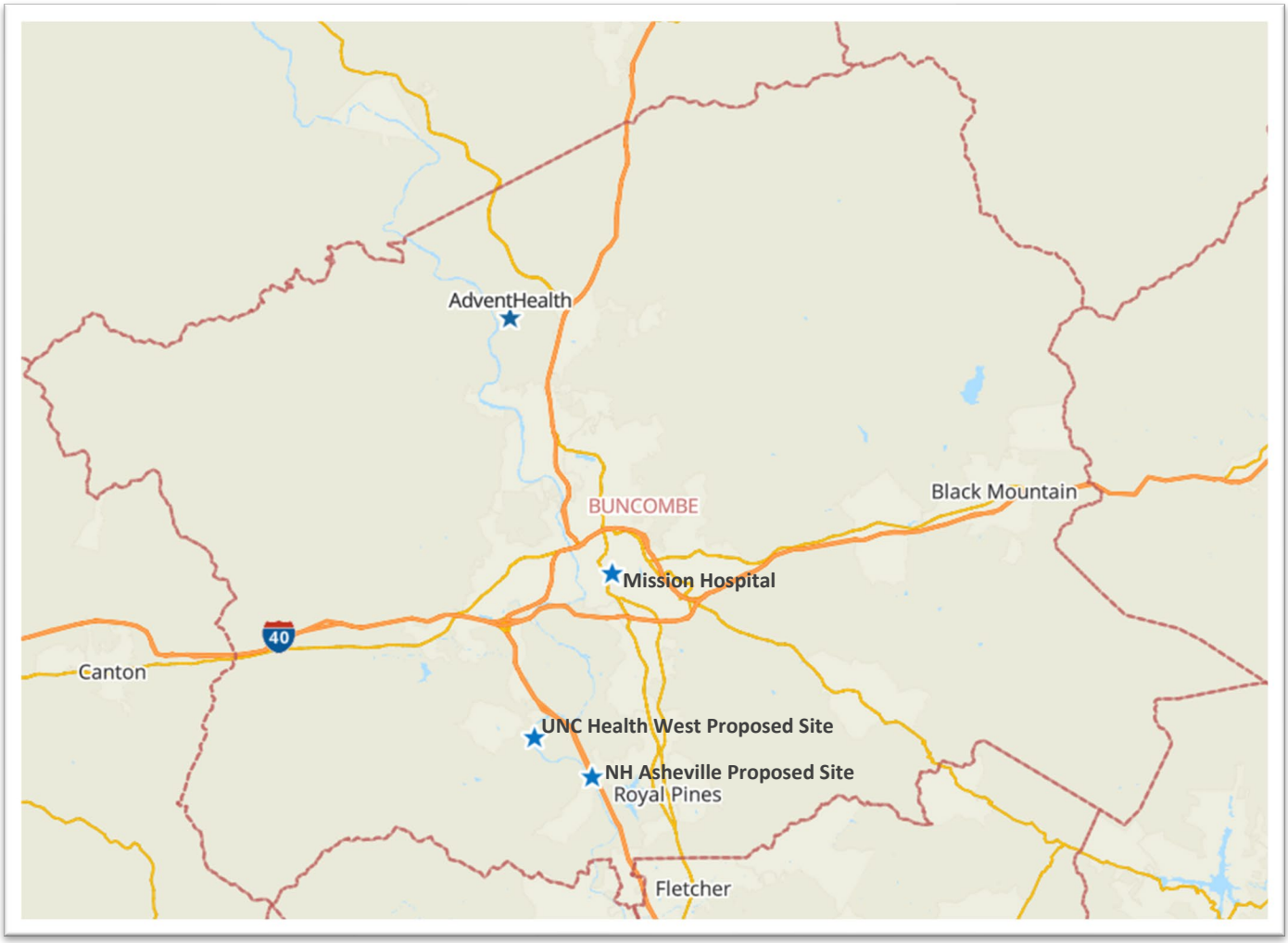
AdventHealth Asheville's proposed scope of services is the most balanced, community-driven, and operationally effective alternative, making it the superior application under this comparative factor.

Geographic Accessibility

There are 733 existing licensed acute care beds, which are all currently located in Asheville (Buncombe County) at Mission Hospital. Mission proposes to develop 129 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 433 Long Shoals Drive in Arden. UNCHW proposes to develop a new acute care hospital located at the intersection of Brevard Rd and Frederick Law Olmsted Way. Neither proposed site will improve geographic access because they will both be located in an area that is already serviced by Mission Hospital, AdventHealth Hendersonville, and UNC Pardee. The following map shows the proposed facility locations in this competitive batch review.

Facility Locations for 2025 Acute Care Bed Review



NHAMC and UNCHW's proposed locations are each less than four miles from the Henderson County line. NHAMC and UNCHW 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.

Madison and Yancey County residents will have to travel significant distances to receive the proposed services at UNCHW or NHAMC. Residents of Micaville in Yancey County will have to travel approximately 50 miles (54 minutes) to NHAMC and similar distance and time to UNCHW as well. Residents of Hot Springs in Madison County will have to travel 43 miles (57 minutes) to UNCHW. As the following tables demonstrate, AdventHealth Asheville will provide more favorable geographic access for residents of Madison and Yancey counties than both UNCHW and NHAMC.[13]

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

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 UNC Health West

	Madison Co.			Yancey Co.		Graham Co.	
	Marshall	**Mars Hill**	**Hot Springs**	**Burnsville**	**Micaville**	**Robbinsville**	**Fontana Dam**
Miles	27	31.0	43	43	49	92	95
Minutes	35	25	57	49	56	1hr, 48 mins	1 hr, 49mins

Source: Google Maps

Driving Distances from Madison & Yancey County to AdventHealth Asheville

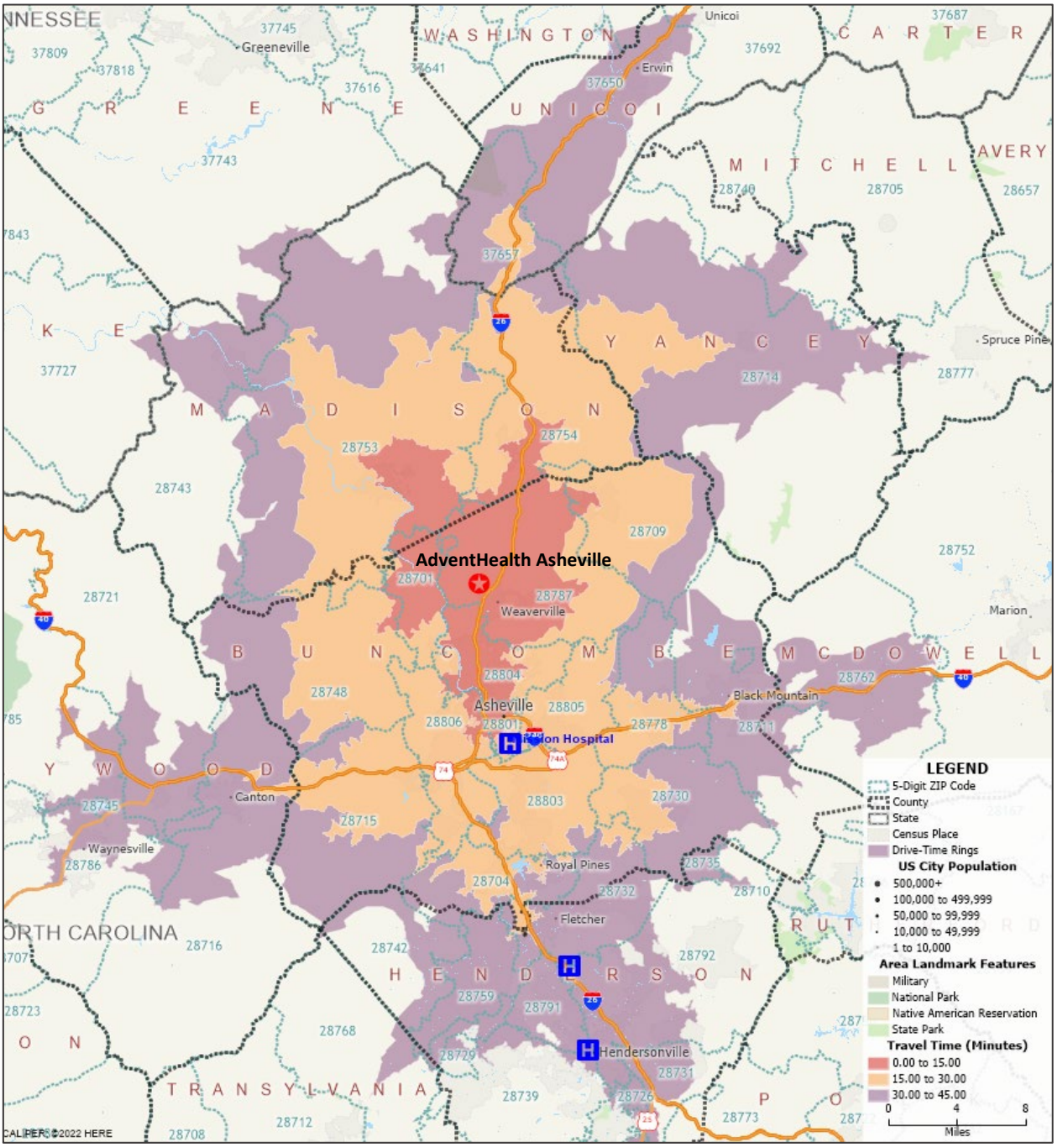
	Madison Co.			Yancey Co.		Graham Co.	
	Marshall	**Mars Hill**	**Hot Springs**	**Burnsville**	**Micaville**	**Robbinsville**	**Fontana Dam**
Miles	10.3	10.0	25.9	27.1	32.3	97.5	99.2
Minutes	16	13	37	32	38	1 hr, 56 mins	1 hr, 55 mins

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. Both UNCHW And NHAMC's proposed locations are 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 enhance access for the specific service area counties, particularly Madison and Yancey. 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.

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 2025 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 2025 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 and 2024 Buncombe/Graham/Madison/Yancey Acute Care Bed Reviews 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. However, Mission's 2025 application is not approvable because it does not conform to multiple statutory review criteria, therefore, the Agency can and should assess access by service area residents between AdventHealth Asheville and NHAMC and UNCHW.

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	27,352	57.2%
Novant Health	1,065	68.1%
AdventHealth	**10,991**	**90.0%**
UNC Health West	5,208	63.0%

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 only 68.1 percent of patients will originate from

the four-county service area. While UNCHW projects to serve just 63 percent. Therefore, AdventHealth is a **more effective** alternative regarding access by service area residents than both NHAMC and UNCHW.

Historical Utilization

In previous acute care bed reviews, the Agency has attempted to assess historical utilization among the competing applicants. However, AdventHealth Asheville, UNCHW 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

Applicant	Form F.2b Total Medicare Revenue	Form F.2b Gross Revenue	% of Gross Revenue
Mission	$5,185,498,865	$8,968,527,774	57.8%
Novant Health	$85,847,244	$144,281,083	59.5%
AdventHealth	$408,222,458	$606,492,204	**67.3%**
UNC Health West	$445,192,601	$879,522,613	50.6%

Source: CON applications

AdventHealth Asheville proposed to provide the highest Medicare percentage of gross revenue during the third project year.

When comparing applicants on access for Medicare beneficiaries, the percent of gross revenue attributable to Medicare, not the absolute dollar amount of Medicare revenue, is the only valid, apples-to-apples metric.

Absolute Medicare revenue is driven primarily by two unrelated structural factors:

1. Size of the facility (number of beds): A system with 500+ acute care beds will inevitably generate far more total gross revenue, and therefore more Medicare revenue, than a system operating 90–200 beds. This difference says nothing about the applicant's *willingness* to serve Medicare patients.
2. Average gross charges: Applicants with higher charge structures will mechanically post higher Medicare gross revenue, even if they treat *fewer* Medicare patients. Gross revenue reflects hospital charge levels, not access, payor mix, or equity.

Because these factors vary dramatically across the applicants, comparing total Medicare dollars obscures, rather than reveals, actual Medicare access.

By contrast, percent of gross revenue from Medicare standardizes each applicant's portfolio and shows the *proportion* of their services projected to be delivered to Medicare beneficiaries. It is the only measure that neutralizes differences in bed size, charge structures, and service mix. This allows the Agency to evaluate which applicant actually commits a larger share of its business to Medicare recipients.

AdventHealth demonstrates the strongest Medicare access commitment with the highest Medicare percentage (67.3 percent).

UNC projects the lowest Medicare percentage despite large projected volumes and a high-charge structure.

Mission's projected Medicare percentage of gross revenue is below both AdventHealth and Novant despite its immense scale.

In short, using raw Medicare revenue would reward the largest and highest-charging applicants, not the applicants most committed to serving Medicare beneficiaries. Percent of gross revenue removes this bias and allows the Agency to compare the applicants fairly and accurately.

For these reasons, **AdventHealth** is the **most effective** alternative regarding access to Medicare.

Projected Medicaid

The Agency should evaluate Medicaid access in the context of where Medicaid-eligible residents actually live. In this review, access for service area residents and access for Medicaid beneficiaries are effectively the same issue, because the highest-poverty, highest-Medicaid counties in the service area are also the counties with the greatest geographic barriers to care.

Applicant	Service Area Residents Served	% of Total Patients
Mission	27,352	57.2%
Novant Health	1,065	68.1%
AdventHealth	10,991	**90.0%**
UNC Health West	5,208	63.0%

Source: Section C.3 of competing applications

AdventHealth is the only applicant projecting that its hospital will primarily serve the residents who actually live in the four-county service area. Fully 90 percent of AdventHealth's projected patients are from Buncombe, Madison, Yancey, and Graham Counties—nearly 30 percentage points higher than UNC Health West.

The service area residents are disproportionately low-income and Medicaid-eligible.

	Buncombe County	Madison County	Yancey County	Graham County
2023 Persons in Poverty, Percent	12.9%	13.8%	15.9%	16.9%

Source: NC Rural Center (ncruralcenter.org)

Because poverty correlates directly with Medicaid enrollment, the residents of these counties, particularly Madison and Yancey, represent the highest-need Medicaid population in the service area. Thus, an applicant cannot demonstrate meaningful Medicaid access unless it also demonstrates meaningful access for service area residents, because the two groups substantially overlap.

AdventHealth projects:

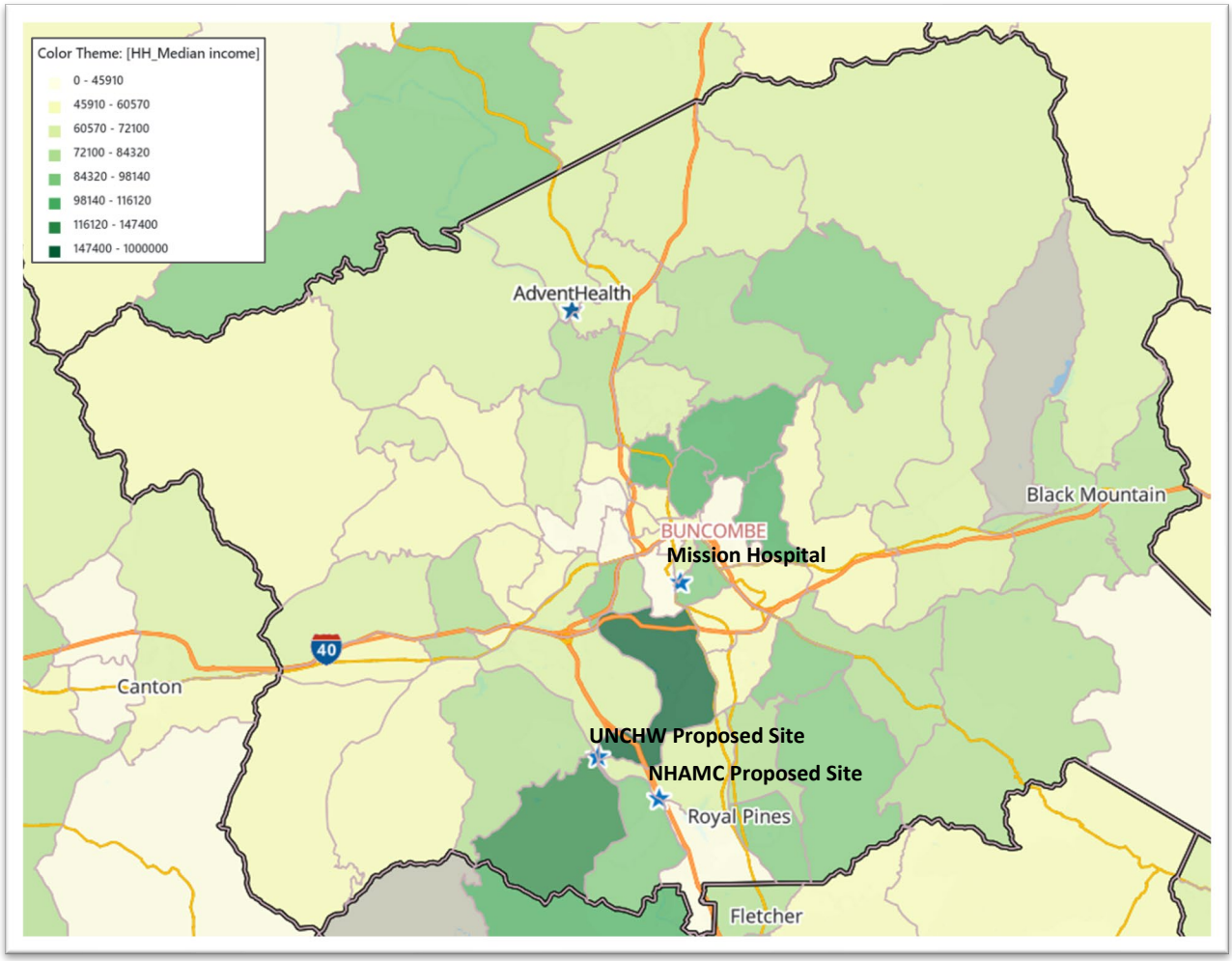
- 90% of patients from the service area, and
- A hospital location that is geographically positioned to serve the rural, high-poverty, high-Medicaid counties.

This means AdventHealth's entire operational model is aligned with the population that actually needs Medicaid access.

By contrast:

- NHAMC and UNC Health West locate their proposed hospitals in the wealthiest census tracts in Buncombe County,
- Far from Madison and Yancey County,
- And project far lower percentages of patients from the actual service area.

Median Household Income by Census Tract, 2025



Source: Maptitude

If a facility does not serve the service area, it cannot serve the Medicaid population that lives there.

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

Projected Medicaid Revenue: Inpatient Services – 3rd Full FY

Applicant	Form F.2b Total Medicaid Revenue	Form F.2b Gross Revenue	% of Gross Revenue
Mission	$1,030,541,893	$8,968,527,774	11.5%
Novant Health	$17,025,168	$144,281,083	11.8%
AdventHealth	$52,000,850	$606,492,204	**8.6%**
UNC Health West	$107,566,986	$879,522,613	12.2%

Source: CON applications

While Mission, Novant, and UNCHW show somewhat higher Form F.2b Medicaid percentages, those projections are not meaningful because:

- Their hospitals are located in higher-income areas with lower Medicaid prevalence.
- Their service-area-resident projections show they will not draw significant volume from the counties where the Medicaid population resides.
- Their payer-mix projections are not supported by geography, demographics, or access patterns.

AdventHealth is the only applicant whose projected patient population aligns with the geography of the service area and the location of the rural, high-poverty, high-Medicaid counties. For these reasons, **AdventHealth** is the **most effective** alternative regarding access by Medicaid.

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	47,818	$1,467,076,661	$30,680
Novant Health	1,565	$40,099,621	$25,623
AdventHealth	12,212	$177,316,951	**$14,520**
UNC Health West	8,262	$269,033,814	$32,563

Source: CON applications

In the previous 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 2025 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 and UNCHW.

AdventHealth projects the lowest projected average net revenue per patient of the competing proposals. AdventHealth Asheville projects an average net revenue per discharge that is less than half of what UNCHW projects during the third project year and 43% less than NHAMC. This comparison of projected average net revenue per discharge shows the stark contrast in affordable rates. Clearly, neither Novant nor UNCHW's proposed projects 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.

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	47,818	$848,339,411	$17,741
Novant Health	1,565	$39,681,621	$25,356
AdventHealth	12,212	$174,238,746	**$14,268**
UNC Health West	8,262	$238,929,459	$28,919

Source: CON applications

In the previous 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 2025 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 and UNCHW.

UNCHW projects the highest average operating expense per patient. NHAMC projects, a higher average operating expense per patient than AdventHealth. As explained in AdventHealth's application, development of a micro specialty hospital with only 34 acute care beds is not the most effective alternative for the need determination in the 2025 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 both NHAMC and UNCHW regarding average operating expense per patient.

Quality of Care

Quality of care is a critical comparative factor in this review, particularly given the well-documented safety concerns within the service area. The Agency must prioritize applicants that can reliably deliver safe, high-quality care to residents of Buncombe, Graham, Madison, and Yancey Counties. When evaluated against this standard, AdventHealth is clearly the most effective alternative.

Mission Hospital is not a viable option regarding quality. As detailed in AdventHealth's written comments on the Mission application and Criterion (20), Mission has an extensive history of Immediate Jeopardy citations, ongoing regulatory deficiencies, and documented failures in emergency care that placed patients at risk of serious harm. While Mission currently holds a "B" Leapfrog Safety Grade, this rating does not outweigh multiple years of severe CMS findings or the substantial evidence of persistent safety shortcomings. Mission's proposal does not improve quality, it prolongs a pattern of unacceptable risk.

Novant Health presents mixed performance. Novant Health New Hanover Regional Medical Center holds a "C" Leapfrog Safety Grade for Fall 2025 and a two-star CMS Overall Quality Rating. These results do not demonstrate a consistent ability to deliver high-quality care comparable to AdventHealth.

UNC Health Pardee, the closest UNC-affiliated hospital, holds a "B" Leapfrog Safety Grade. While adequate, this performance is average and does not represent the level of excellence required to meet the significant quality challenges facing the service area. Moreover, UNC's proposed West Asheville facility has no operational track record, and its performance cannot be assumed to mirror other UNC hospitals, particularly given Pardee's underutilization and projected bed surplus.

AdventHealth is the only applicant with a consistent, verifiable record of high-quality performance in the region. AdventHealth Hendersonville maintains an "A" Leapfrog Safety Grade, a 5-star CMS Overall Quality Rating, strong patient experience scores, and no Immediate Jeopardy findings in recent years. AdventHealth has demonstrated reliable, safe, and patient-centered care in Western North Carolina and is uniquely positioned to replicate this performance at AdventHealth Asheville.

Given the urgent need to raise the standard of care in the service area, AdventHealth is the clear superior alternative under the quality-of-care comparative factor.

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
- Access by Medicare
- Access by Medicaid
- Average Net Revenue Per Patient
- Average Operating Expense Pet Patient
- 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.

Novant Health's application fails to conform with all applicable statutory and regulatory review criteria; thus, it cannot be approved. In addition, UNC Health West'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

AdventHealth Asheville is the only application that fully conforms to all applicable statutory and regulatory review criteria, including the criteria addressing access for service area residents, access for Medicaid beneficiaries, geographic accessibility, competition, need, and quality. When evaluated through a comparative lens, AdventHealth Asheville is markedly superior to the applications submitted by Mission, Novant Health, and UNC Health West.

AdventHealth Asheville's proposal will:

- Enhance the scale and scope of the approved acute care hospital to meet growing demand in the service area;
- Increase patient access to acute care services for residents across Buncombe, Graham, Madison, and Yancey Counties;

- Improve geographic access, particularly for rural residents who currently face long travel times and limited hospital choice; and
- Enhance patient and family choice, bringing meaningful and further enhance long-overdue competition to Buncombe County and the broader region.

For all these reasons, the application submitted by AdventHealth Asheville is the most effective alternative and should be approved as submitted.

ATTACHMENT:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES

STATEMENT 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 09/26/2025

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 September 15, 2025 through September 19, 2025 and September 22, 2025 through September 26, 2025 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 September 25, 2025 at 1610 as a result of incidents that occurred on July 26, 2025, August 19, 2025, September 4, 2025 and September 16, 2025. Specifically pursuant to §482.13 Patients' Rights and §482.23 Nursing Services, the hospital staff failed to provide a safe environment for patients by failing to have systems in place and followed to ensure continuous monitoring of a patient during transport, to follow established telemetry escalation processes and to promptly correct and mitigate risks related to patient misidentification. Nursing staff failed to respond to and assess a telemetry patient with emergent needs and failed to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport and failed to prevent and control infections by not accurately identifying and communicating infection prevention precautions. The effect of these practices resulted in an unsafe environment for patients. 1. Patient #14, a 72-year-old, presented to the hospital on 07/23/2025 for shortness of breath and chest pain. Findings revealed the patient had an order for continuous telemetry monitoring. On 07/26/2025 at 0021, Patient #14 was noted to have an oxygen saturation of 93% on 60 liters of high flow humidified oxygen. Video review revealed staff were in Pt #14's room from	A 000		

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

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A 000	Continued From page 1	A 000		

0012-0024. Review of Centralized Monitor Unit (CMU) tech documentation noted an RN was notified at 0242 that Patient #14's telemetry leads were off. No nurse was noted on video monitoring entering the patient's room after the notification of leads off. No nursing staff were viewed to have entered the room after 0024. A staff member, identified as a Respiratory Therapist (RRT), per video entered the room at 0305 and exited at 0305. Vital signs documented by the RRT at 0320 were heart rate 78, respiratory rate 18 and SpO2 93% on the same high flow oxygen. CMU notes revealed an attempt to contact nursing staff at 0309, "called no answer left text," and again contacted nursing staff at 0312 and 0326. Video review revealed a staff member, identified as a Patient Care Tech, entered the room at 0346 (64 minutes after first notification of leads off). Patient # 14 was found on the floor unresponsive. A code blue was called at 0347. Time of death was called at 0403 on 07/26/2025.

2. Patient #10, a 48-year-old, presented to the Emergency Department (ED) on 09/04/2025 at 1441 with complaints of chest pain and shortness of breath. The patient experienced 10 out of 10 pain at 1808 and was unable to receive Morphine due to low blood pressure (84/57). The patient was transported from the ED to a Stepdown unit by a nonclinical transporter at 1830 with an order for continuous pulse oximeter. Findings revealed the pulse oximeter did not have continuous signal once the patient left the ED. The patient was moaning in pain and requesting nursing help during transport. The patient arrived to the unit (time not documented), was transported to the room, observed to have seizure-like activity, and a code blue was called at 1842. There was no documented evidence of oxygen saturations

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A 000	Continued From page 2	A 000		

during transport and no call from the CMU Tech. The time of death was called at 1907.

3. Patient # 24, a 73-year-old, arrived to the Emergency Department by EMS on 08/19/2025 at 0003. Findings revealed Patient #24 was quick registered (initial registration to get a patient into the system for identification) incorrectly as another patient with a similar name and same birthdate. The staff member who completed the quick registration indicated they requested the patient name and birthdate from EMS and thought the patient's actual given name was a nickname. Patient #24 was incorrectly identified. A new encounter was started under an incorrect patient's medical record. The error was identified when registration staff went to complete the registration process. Provider orders and notes were already documented in the wrong medical record/encounter and no corrections were able to be immediately implemented. Patient #24's medical information, including medication administration, continued to be documented in the incorrect medical record. The medical history and home medication list included medical information that did belong to Pt #24. The medical records were not merged until 8/19/2025 at 1729, over 17 hours later. Provider notes were amended 09/10/2025 (22 days later) or later. The delays and inaccurate medical information created an unsafe environment for patient care.

Hospital leadership was notified of the Immediate Jeopardy (IJ) identification on September 25, 2025 at 1610. The facility brought action plans related to each of the 4 incidents. After review of the action items, the IJ was determined to be ongoing for the three incidents dated July 26, 2025 (Patient #14), September 4, 2025 (Patient

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A 000	Continued From page 3	A 000		

#10) and August 19, 2025 (Patient #24).

4. Specifically, pursuant to §482.13 Patients' Rights, §482.23 and Nursing Services the hospital nursing staff failed to ensure a safe environment for patients by failing to assess and transition COVID positive patients from the ED to inpatient status under the appropriate isolation precautions and notify family members. Nursng staff failed to acknowledge the patient was COVID positive, prevent and control infections by failing to accurately and timely communicate precautions for implementation. Faciliy failed to notify family of a positive COVID PCR until forty-eught hours after results.

Patient # 34, presented to the ED and was admitted September 16, 2025. The patient was placed on a pulmonary medical unit (per staff interview previously treated COVID positive patients). During observation and tour of the unit on 09/18/2025, staff members indicated there were zero COVID positive patients on the unit at that time. During observation, the isolation sign on the door of Patient #34's room was for contact precautions, not enhanced COVID precautions. Medical record review revealed Pt #34 was tested for COVID 19 with a positive result on 09/16/2025. Family inteview 09/18/2025 indicated hospital staff failed to inform the family of a COVID positive PCR on 09/16/2025 and appropriate precautions until 09/18/2025. According to hospital data, fifteen staff were assigned or potentially exposed to COVID.

Interview revealed that due to a programming error, the computer changed the isolation to contact precautions from enhanced (COVID) precautions. The patient's nurse, per interview,

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A 000	Continued From page 4 acknowledged the order change and removed the previous enhanced COVID procaution sign and replaced it with the contact isolation sign. No one voiced awareness of a COVID patient on the unit or in that room or questioned the isolation precaution change until a physician noticed the error. Hospital leadership staff was notified of the IJ identification on September 25, 2025. Based on actions taken by facility, the IJ was determined to be abated for the incident that started September 16, 2025 (Patient #34).	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, observations, medical record review, CMU (Central Monitoring Unit) documentation, hospital document reviews 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 receive care in a safe environment; 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:	A 043		

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A 043	Continued From page 5 1. Hospital staff failed to provide a safe environment for 3 of 32 patients reviewed by failing to ensure systems were in place and functioning for continuous pulse oximetry monitoring of a patient during transport (Patient #10), to provide timely response and patient evaluation to telemetry monitor alarms (Patient #14) and to provide accurate patient identification during initial quick registration and promptly correct the electronic misidentification and mitigate the associated risks (Patient #24). Cross refer to §482.13 Patient Rights' Standard: Tag A 0144. 2. The hospital failed to ensure adequate staff was available to assess and respond to a monitored telemetry patient with leads off and the patient subsequently expired for 1 of 32 patients reviewed (Patient #14). Cross refer to 482.23 Nursing Standard: Tag A 0392. 3. Nursing staff failed to supervise and monitor care by failing to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport (Pt #10) and failing to prevent and control infections. Nursing staff failed to identify and communicate accurate and timely COVID precautions on an inpatient unit creating an unsafe environment for patient care (Pt #34). Cross refer to 482.23 Nursing Standard: Tag A 0395 4. Hospital nursing staff failed to follow policies to	A 043		

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A 043	Continued From page 6 evaluate a patient's change in condition requiring emergent treatment for 1 of 32 sampled patients (#17) and failed to follow post procedure guidelines following a heart catheterization for 2 of 32 sampled patients (#17, #15) Cross refer to 482.23 Nursing Standard: Tag A 0398 5. Emergency Department (ED) staff failed to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport from the ED to an inpatient unit for 1 of 12 emergency department patients reviewed (Patient #10). Cross refer to §482.55: Emergency Services Standard Tag A 1103.	A 043		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on hospital policy review, medical record review, and staff and provider interviews, the hospital failed to protect and promote patients' rights by failing to ensure care in a safe environment for 3 of 32 patients reviewed (Pt #10, #14, #24). The findings included: 1. Hospital staff failed to provide a safe environment for 3 of 32 patients reviewed by failing to ensure systems were in place and functioning for continuous pulse oximetry	A 115		

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A 115	Continued From page 7 monitoring of a patient during transport (Patient #10), to provide timely response and patient evaluation to telemetry monitor alarms (Patient #14) and to provide accurate patient identification during initial quick registration and promptly correct the electronic misidentification and mitigate the associated risks (Patient #24). Cross refer to §482.13 Patient Rights' Standard: Tag A 0144.	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on policy review, observation, medical record review and staff and physician interviews, the hospital staff failed to provide a safe environment for 3 of 32 patients reviewed by failing to ensure systems were in place and functioning for continuous pulse oximetry monitoring of a patient during transport (Patient #10), to provide timely response and patient evaluation to telemetry monitor alarms (Patient #14) and to provide accurate patient identification during initial quick registration and promptly correct the electronic misidentification and mitigate the associated risks (Patient #24). The findings include: 1. Review of hospital policy "Physiologic Monitoring - Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring - 1PC.NRS.0001," effective 08/19/2025, revealed, " ... III. Transport of Monitored Patients. 1. Interruption in cardiac monitoring should not	A 144		

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occur during transport for patients with active orders for telemetry monitoring. a. Patients with active monitoring orders should continue to be remotely monitored, and the Monitor/Telemetry Technician should be notified of unit travel, destination, primary contact for duration of travel, and anticipated time of return ... V. Telemetry Escalation Process ... 3. In the event a non-lethal arrhythmia is detected, pulse oximetry (SPO2) reading <87%, OR patient's cardiac rhythm is not transmitting, the Monitor/Telemetry Technician will initiate the following procedure: a. The Monitor/Telemetry Technician will initiate a multi-level escalation process, requiring loop closure/alarm resolution within 5 minutes of the initial arrhythmia alarm ..."

Review of hospital policy attachment "Example Telemetry Escalation Pathways," effective 08/16/2025, revealed, "Immediate Escalation & 5 Minute Resolution: Non-lethal Rhythm, Loss of Signal (no transmission) or SPO2 <87%. TT (Telemetry Tech) immediately call Primary Nurse - Unable to reach Primary Nurse and/or issue not resolved within 2 minutes - TT to call Charge Nurse - Unable to reach Charge Nurse and/or issue not resolved within 3 minutes - Call overhead Telemetry Alert, repeat once per minute until resolved ..."

Observation of the Emergency Department (ED) on 09/23/2025 at 1159 revealed a patient was switched from ED telemetry monitoring to the CMU (Central Monitoring Unit) for monitoring during transport to inpatient holding. Observation revealed the portable telemetry box did not display a visual or have an audible alarm for any changes during transport.

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Closed medical record review on 09/17/2025 for Patient #10 revealed a 48-year-old presented to the ED on 09/04/2025 at 1441 with complaints of chest pain and shortness of breath. The patient's pain was documented at 1442 as 8 out of 10. The Provider's MSE (Medical Screening Exam) Note at 1445 revealed, "Patient with chest pain and shortness of breath. On home oxygen normally. chest tube in place. Patient is alert, in no acute distress but is moaning in discomfort." The patient's oxygen saturation (O2 sat) at 1500 was 90%. The ED Provider's Note at 1534 revealed the patient had a history of metastatic lung cancer with a chest tube on the right with "chronic pain at the tube site now with worsening shortness of breath for the past day." The patient's O2 sat at 1630 was 92%, and the patient was placed on 3 liters of oxygen via nasal cannula. The patient's O2 sat at 1715 was 93%. An order for Morphine (a pain medication) 4 milligrams IV (intravenous) was placed at 1729. An order was placed at 1731 for continuous pulse oximetry (measures how much oxygen is in the blood for uninterrupted periods). The patient's O2 sat at 1745 was 89% and at 1750 was 90%. A broadcast notification was sent to a Stepdown unit at 1803 with the room number the patient was assigned to and the box number for continuous pulse oximetry. The patient's blood pressure at 1807 was 84/57 with a comment by the Nurse that the Provider was notified at that time. The patient's pain was assessed at 1808 as 10 out of 10. A comment was documented on the MAR (Medication Administration Report) at 1809 that Morphine was not given as the patient's blood pressure was "too low to administer," and the Provider was notified. The patient's oxygen was increased to 4 liters at 1820 with an O2 sat of 94%. ED Nurse Note at 1830 revealed the patient was transported by

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transport staff. The patient was on an "O2 monitor, awake and alert" with an O2 sat of 93% prior to transport. Record review failed to reveal documented evidence of the patient's time of arrival to the unit and initial O2 sat on the unit. Review of a Code Record revealed a code blue (the initiation of resuscitative efforts in a cardiac or respiratory arrest) was called with initiation of CPR (cardiopulmonary resuscitation) at 1842 and initial ECG (electrocardiogram, a noninvasive test that records the electrical activity of the heart) rhythm of asystole (no heartbeat). The patient was intubated at 1853, and a rhythm of PEA (Pulseless Electrical Activity, a condition where the heart is still producing electrical signals, but there is no pulse or blood pressure) was noted at 1901. The patient expired at 1907. Record review failed to reveal evidence of continuous pulse oximetry monitoring during the patient's transport and failed to reveal documented evidence of the patient's heart rate and O2 sats during transport.

Interview on 09/16/2025 at 1300 with RN #4 revealed the CMU monitored patients on continuous pulse oximetry (pulse ox), but they did not record the patients' O2 sats.

Telephone interview on 09/22/2025 at 1422 with Staff #7 revealed they were not aware of any alarm that could be heard with the telemetry box during a patient's transport.

Telephone interview on 09/23/2025 at 1313 with Tech #5 revealed they recalled RN #27 called to verify the pulse ox for Patient #10 could be visualized by the CMU prior to transport from the ED to a Stepdown unit. Interview revealed they were on the phone for a few minutes troubleshooting the pulse ox probe as there were

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issues with the signal going in and out. Interview revealed Wi-Fi connection issues, such as the signal cutting in and out, could occur when a patient was transported. Tech #5 revealed during Patient #10's transport, the signal was again cutting in and out, and there was not a solid reading. Tech #5 revealed there were drops in Patient #10's O2 sats, but they could not get a clear reading due to signal issues. Interview revealed the CMU pod was very busy that day as there were multiple patients being transferred and admitted, as well as multiple escalations at that time. Tech #5 revealed any time there were O2 sats dropping or signal loss, the monitor techs should notify the Nurse as soon as they see it with a resolution time of 5 minutes. Interview revealed the Stepdown unit was not notified that Patient #10's pulse oximetry had signal issues, a loss of signal during transport, or drops in the patient's O2 sats.

Interview on 09/25/2025 at 0934 with Nursing Administrative Staff (AS) #6 revealed there was no action plan needed related to Patient #10 as the pulse oximetry signal could be intermittent while transporting patients in the elevator. The telemetry staff should follow the loss of signal pathway, which would give the staff time to contact the Nurse.

Follow-up interview on 09/25/2025 at 1715 with AS #6 revealed there were potential opportunities for signal issues with telemetry during transport, but they were not aware that it was a "profuse issue."

2. Review of hospital policy titled "Physiologic Monitoring - Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring" last approved 06/04/2025 revealed " ...PURPOSE ...

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A 144	Continued From page 12 C. Identify which rhythms or arrhythmias require RN (registered nurse) notification/intervention and identification of proper escalation procedures ...ALARM RESPONSE AND ESCALATION PROCESS A. ...a defined escalation pathway is used to ensure timely notification and treatment ...II. Rhythm Transmitting with ...Leads Off ... A. First Escalation Attempt: 1. MTII (monitor tech) calls Primary Nurse. 2. Within 5 minutes the Primary Nurse will assess the patient and call the monitor tech and give an update ...4. The MTII records the notification ... B. Second Escalation Attempt: 1. If unable to reach Primary Nurse or unresolved within 5 minutes from the time of initial notification, the MTII call the Primary Nurse again and enter notification time ... C. Third Escalation Attempt: 1. If unable to reach Primary Nurse, or unresolved after 5 minutes, the MTII will call the CNC (clinical nurse coordinator)/Relief Charge Nurse. 2. If no resolution after 1 minute, send broadcast to unit. 3. If no resolution after 2 minutes, start escalation over until resolved. Review of hospital policy titled "Assessment and Reassessment" last approved 05/13/2025 revealed "Purpose The organization assesses and reassess the patient and the patient's condition according to defined timeframes ... Policy ... C. The assessment process is a continuous, collaborative effort with departments functioning as an interdisciplinary team ... Assessment Framework A ...2. As individual patient condition changes ..." Review of hospital document titled "ADULT INTERMEDIATE CARE STANDARDS OF CARE GUIDELINES-NURSING", revealed " ...Reassessment intervals and parameters are presented as the minimum times, measurements,	A 144		

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and evaluation criteria ... Patient Rounding A. Safety Rounds to occur as recommended - every 1-2 hours ... Safety A. The patient can expect appropriate safety precautions while in the hospital ..."

Closed medical record review revealed Patient (Pt) #14 was a 72-year-old male readmitted on 07/23/2025 at 1715 for shortness of breath and chest pain. At 1742 there was an order for telemetry monitoring. Per documentation the patient was placed on telemetry and telemetry tech was notified. On 07/26/2025 at 0021 vital signs revealed temperature 98.1 (oral), heart rate (HR) 76, blood pressure (BP) 99/57, (oxygen saturation) SpO2 93% on 60L (liters) oxygen (O2) high flow humidified. At 0320 the RRT (registered respiratory therapist) documented the patients HR 78, respirations (RR) 18, SpO2 93% on 60L O2 high flow humidified. Review of a Provider Note at 0415 revealed "CODE BLUE called overhead on this patient ... Was not notified by staff of any issues overnight or notified of patient being found on the floor prior to CODE BLUE being called. CPR was in progress when I walked in the room. Per the patients nurse, he was found on the floor without his Vapotherm (high flow humidified O2) on and without telemetry on for an unknown period of time ... During discussion with Dr. (named) it was decided to stop the code as we never obtained a pulse. Time of death was called at 0403 ..." Review of the Code Blue documentation revealed code time started at 0347, the patient was intubated at 0354, and the code stopped at 0403. Record review did not reveal a bed/chair alarm was documented on the evening shift of 07/25/2025.

Review of video footage dated 07/26/2025

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revealed footage of unit 4 heart. Review revealed a view of the nursing station, a hallway view of Patient #14's room (E433). From 0012 through 0024 staff were noted to be in Patient #14's room and the 2 staff members exited at 0024. At 0231 a female staff (identified as CNC #14) was seen sitting at the nurse station computer. At 0305 a male staff (identified as [registered respiratory therapist] RRT #21) entered the patient's room and was seen exiting the room also at 0305. At 0313 CNC #14 still observed at nurse station, observed answering the desk phone. At 0322 CNC #14 left the nurse station and walked to another patient's room. At 0346 male staff (identified as unit PCT) entered Patient #14's room. At 0348 the code team arrived via stairwell. Review did not reveal any nursing staff in Patient #14's room between 0024 and 0346, only the Respiratory Therapist at 0305.

Review of the facility investigation on 09/18/2025 at 1535 with Director #13, Director #9, and Nurse Administrative Staff (AS) #6 revealed a timeline of events. The timeline revealed on 07/25/2025 at 1900 an RN rounded on the patient and noted no distress. On 07/26/2025 at 0012 staff were in the patient's room. At 0242 the RN was notified by the CMU tech (central monitoring unit technician) that the telemetry leads were off. At 0244 the RN was notified by the CMU tech again. At 0305 the RRT rounded on the patient and noted no distress. At 0309 the CMU tech sent a text to the RN. At 0312 the CMU tech notified the CNC to reinforce the leads. At 0317 the CMU tech called the RN but did not get an answer. At 0320 the RRT documented HR 78, RR 18, SpO2 93%, Vapotherm at 60L/minute. At 0326 CMU tech called the CNC. The CNC told the CMU tech they were in a rapid response and would get to the

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patient after they transferred the rapid response patient off the unit. At 0341 the CMU tech reached out to the PCT (patient care technician) asking for the telemetry leads to be checked. At 0345 the PCT entered the room and found the patient on the floor. At 0347 a Code Blue was initiated. At 0354 the patient was intubated. At 0403 the Code ended. Further interview revealed that the RRT was interviewed after the incident. The RRT entered the patient's room at 0305 the RRT noted the patient was resting and did not have his telemetry leads on. The RRT used his pocket pulse oximetry to assess the patients SpO2 and noted the RRT had no issues and that he assumed the RN was aware of the leads being off and would get to them. Interview revealed that the CMU tech was interviewed after the incident. The CMU tech revealed that the RN stated someone would get to the patient, so the CMU tech was giving the RN the benefit of the doubt. The CMU tech revealed that it was a busy night, and multiple telemetry patients required his attention at that time. Also, the placement of each patient (patient in the upper right corner of screen vs patient in the left corner of the screen) on his telemetry monitor made it difficult to follow. Interview revealed that the Primary RN and CNC were dealing with another rapid response patient and transfer to the ICU (intensive care unit). Further interview revealed that the RRT and CMU tech were no longer employed at the facility.

Review of CMU tech documentation on 07/26/2025 revealed at 0242 the RN was notified leads were off. At 0309 "called no answer left text". At 0312 RN notified. At 0326 "called rn [sic] she said we will get pt we are transporting right now". Per an interview with AS #6 the CMU tech did not write down all communication between the

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RN and CMU tech.

Interview on 09/18/2025 at 0900 with AS #6 and Director #9 revealed that the CMU staff work 12-hour shifts (7am-7pm or 7pm to 7am), 3 days a week. The CMU has 10 pods and the staffing goal was to have 10 CMU techs, one for each pod, 2 rovers (staff available to assist), and a supervisor/team lead. Interview revealed that the CMU tech can monitor up to 45 telemetry and/or continuous pulse oximetry patients, but the average was 35 patients.

Interview on 09/18/2025 at 1020 with AS #6 revealed that the CMU techs have different escalation pathways to follow depending on the situation. Interview revealed that when all the leads were off the patient needs to be evaluated by the primary RN/nursing staff. When there was no resolution by nursing staff the CMU tech should reach out to the CNC. If no resolution, then the CMU tech calls an overhead telemetry alert page throughout the specific unit. The escalation process should be repeated until there was a resolution. The expectation of the overhead call was for all staff to respond. Interview revealed that on 07/26/2025 the CMU tech reached out to the RN and CNC but they were busy with another rapid response patient. Interview revealed when there was no resolution the CMU tech did not follow the escalation pathway and call overhead, nor did the RN delegate the responsibility to get the patient assistance.

Interview on 09/22/2025 at 1415 with CNC (Charge Nurse) #14 revealed the CNC recalled the patient and incident. Interview revealed that the CNC was not aware that the patient was off

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telemetry until CMU called the CNC and by that time the CNC was in the rapid response. The CNC stated that she informed CMU they were in a rapid response and to call overhead and CMU said ok, but the CNC did not recall if that happened. The CNC stated she was not aware that CMU had been calling the primary RN because the RN didn't tell the CNC or delegate someone to check on the patient. Interview revealed that on the (named) unit all the RNs are paired with a buddy and that the primary RN should have called the buddy to check the patient. The CNC stated that the RN buddy was not in the rapid response and should have been available. Interview revealed that telemetry monitors can also be seen at the nurse station. The CNC did not recall any unit staff member on 07/26/2025 mention seeing the patient in E433 off of his telemetry monitor. Interview revealed that during the Code Blue debrief the RRT mentioned he told someone about the patient leads being off, but the CNC was not aware of the RRT alerting anyone. Further interview revealed that during the day shift rounding should take place every hour, and overnights between 10pm and 6am, the patient should be rounded on every two hours by either the RN or PCT. Interview revealed that the staffing ratio on the unit was one RN to five patients. On 07/26/2025 the CNC recalled that none of the RNs had more than five patients. Interview revealed that although the staff were within ratio the CNC felt the unit still had a staffing shortage and while staff do their best to provide care, it was not always safe care.

3. Review of the policy titled "Patient Identification...", last approved 08/09/2024, revealed "...POLICY: A. This policy establishes a mechanism to assure that all patients of (hospital)

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are positively identified using two patient-specific identifiers at every encounter. B. Name and date of birth....are the two preferred identifiers....C. Whenever possible, the patient should be asked to state name and date of birth. The patient may also be asked to spell the last name....F. The staff member placing the identification....bracelet on the patient will verify the identity of the patient or have the patient's legal representative do so. ..."

Review of a policy, reference number "PARA.HSC.FB.24", effective 10/21/2024, revealed "...DEFINITION: TRUE OVERLAY/ PATIENT OVERLAY - One individual person/patient's information is mixed in with or on top of another patient's information. This occurs when a patient is registered for a visit or service on another patient's medical record number. PURPOSE:....a standardized method of correcting patient medical records when an overlay has occurred.... The HIMD (Director Health Information Management) will notify.... to review the clinical information in the record on both records for accuracy.... must be remedied within 45 days of the EMPI (Combine) Team's sending of the overlay notification... ."

Medical record review on 09/18/2025 revealed Patient (Pt) #24, a 73-year-old, arrived to the hospital on 08/19/2025 at 0003 via EMS (Emergency Medical Services) as a transfer from an outside hospital. Pt #24 fell off a truck and sustained a pelvic fracture. Record review revealed a "COMBINE" note, signed on 08/20/2024 at 1443, that noted "...This patient had a duplicate Medical Record Number and/or Community Person ID number. A combine was done and the following was changed...._X_

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Financial Number.... This patient's encounter was moved.... Incorrect patient chosen during registration."

Review of an "ER Report" service date/time 08/19/2025 at 0018, revealed Pt #24 "...was on top of a barrel of hay and pulling a tarp on it, he lost his balance falling off the truck and landed on his right hip and back. He was taken to an outside hospital, had CT scan (Computed Tomography - type of imaging procedure) of the pelvis showing right pelvic fractures ....He has been unable to stand or bear weight.... Will admit to the hospitalist for pain control, PT/OT (Physical Therapy/Occupational Therapy) and potentially rehab placement. ..." Review of the "Hospital Medicine Admission H&P (History and Physical)", service date 08/19/2025 at 0217, revealed addenda signed 09/10/2025 at 1011(22 days after arrival). The first addendum stated "...Correction to the H&P above: Patient has never smoked tobacco and the problem 'former tobacco use' should be removed from his social history and problem list above." The second addendum noted "Please see corrections to the medical H&P below: Please note and remove the following from the H&P above. There is no prior history of coronary artery disease, no history of peripheral arterial (circulatory condition with narrowed blood vessels and reduced blood flow to the limbs); no history of tobacco use, and no history of hypothyroidism (thyroid gland does not produce enough thyroid hormone), and no history of BPH (Benign Prostatic Hyperplasia - enlarged prostate gland). [space] Past Medical History: Type 2 Diabetes mellitus (chronic disease when the body does not produce enough insulin or does not use insulin effectively resulting in elevated blood sugar), Hypercholesterolemia (elevated

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cholesterol), Hypertension (elevated blood pressure)... ." An "Orthopedic trauma consultation..." note, originally signed on 08/19/2025 at 1952, revealed an Addendum on 09/17/2025 at 1231 that stated "Please note that due to a clerical error at the time of the original date of service, a portion of the consultation note above contains inaccurate information. Specifically, I have just now been informed that a portion of the past medical history as documented above is inaccurate, and actually applicable to a separate patient of a similar nature. ..." On 08/19/2025 at 1727 an electronic system generated order was for "Order: Chart Merge Notification Order Date/Time 8/19/2025 17:27 EDT.... Order Comment: Immediate medication history and allergy review required due to patient chart merger. ..." The action was documented as complete 08/19/2025 at 2112 (21 hours after the patient's arrival). Review of a "Progress Note", dated 08/19/2025 at 2109 revealed "...Pt has remained in the ED throughout the day....Pt denies significant pain, no med changes or medical issues. Discussed plan of care ....all questions answered. ..." Review of "Allergies - Medications" revealed documentation that allergies were reviewed and validated by an RN on 08/19/2025 at 0013 and were again reviewed on 08/20/2025 at 0734. On 08/20/2025 at 0758, under "Notifications", the note read "...Admission is complete. Med Rec was already done. Med Hx updated for you to review.... has an allergy to codeine. I've added that in. ..." Review of the Discharge Summary, service date/time 08/20/2025 at 1244, revealed an Addendum dated 09/12/2025 at 0229 that noted "Patient has no history of coronary artery disease, BPH, tobacco abuse, peripheral vascular disease. Patient has a history of T2DM (type 2 diabetes)

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hypertension (high blood pressure), hyperlipidemia presented with pelvic fracture.... fracture was closed by consulting orthopedics and recommended nonsurgical management. His home med list is inaccurate as well. Chart mixup happened at arrival. Patient's med list is inaccurate except for pain medications. Updated medical conditions of her (sic) pelvic fracture, T2DM, HTN (hypertension, high blood pressure) and hypokalemia (low potassium)." Further review of Pt #24's medical record revealed scanned documents from the transferring hospital which noted Pt #24's full given name. It was unclear when these records were received. Patient #24 was discharged on 08/20/2025.

The Triage Nurse was requested but was not available for interview.

Interview with Registration Staff (Staff #34) on 09/19/2025 at 0935 revealed Patient #24 came through the ambulance entrance and was quick registered by the ED HUC (Health Unit Coordinator). Interview revealed "once the doctor has signed up for the patient we (registration staff) can register the patient (complete the registration process)." Interview revealed registration asked patient/family "is this (patient's first name)" and the answer was no. Interview revealed Staff #34 verified that the patient name that was chosen in the system was not the same as the patient currently in the ED. Staff #34 went back out and explained to the HUC and Charge Nurse that the patient name in the system was not the patient in the ED. Staff #34 stated "I cannot register this patient due to this being someone else's chart... last name and date of birth were correct, first name was not correct." Interview revealed they discussed if there was

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identification that could confirm the correct name; the answer was yes and noted the patient was a transfer. Interview further revealed staff went to the patient's family apologized that they could not register the patient now but would get it fixed. Staff #34 stated the patient's correct name and the incorrect patient name both were listed on the "board". Interview revealed they could not initially register Pt #24 with the patient's correct name because labs and orders had already been recorded in the other record. Interview revealed they "can't do anything, would lose everything." Reg Staff #34 further indicated that Pt #24's armband had the correct sticker placed on top of the armband that had incorrect information.

Telephone interview on 09/19/2025 at 1130 with MD #36, revealed the MD was involved in the care of Pt #24. Interview revealed it was an overnight admission. Interview revealed MD #36 had no idea Pt #24 was registered under the wrong name. MD #36 stated s/he met with the patient only the one time, around 0200 for the admission H&P. Interview revealed physicians went in and did addendums to correct the medical record afterwards.

Telephone Interview with MD #1(a physician leader), also at 1130 on 09/19/2025 revealed MD #1 was notified of the error and reached to MD #36 to discuss it.

Interview with Registration Staff #35 on 09/19/2025 at 1155, revealed Staff #35 remembered another staff member had attempted to register the patient and learned the computer encounter in the system for Pt #24 was incorrect. Staff #35 pulled up the encounter and it was the wrong person. Orders had already been

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entered. Interview revealed "it is not something I can fix." Staff #35 stated there was a combine team and noted "it's an urgent thing but my only avenue to fix it was to reach out to the team." Interview revealed it happens on a regular basis and "...if orders are already in, it is very difficult to correct. Before orders, the chart can be errored out...quick fix.... If beyond that....has to be dealt with by another group."

Telephone interview with HUC #37 on 09/19/2025 at 1220 revealed Pt #24 came through and EMS gave patient's name and DOB. Interview revealed the HUC did not recall but did not think there was paperwork with the patient. Interview revealed the HUC mostly asked EMS and if unable to locate the name would then get more information. Interview revealed HUC #37 put in the patient's last name, then stated a first name (incorrect first name) and they said yes so that record was selected. A few hours later, the HUC stated, family members came and said it was wrong and gave Pt #24's ID. The patient received a new medical record number and a new bracelet and stickers, interview revealed. HUC #37 indicated the "Combine team" was e-mailed because "they are the ones who do changes." Interview revealed the next day the patient still had two accounts. Interview further revealed tonight "...would still ask EMS ... if can't find ask the patient."

Telephone interview with MD #38 on 09/19/2025 at 1300 revealed the physician recalled the patient and stated that issues like this do happen. The MD stated generally if no orders had been placed they can correct; in this case the issue wasn't caught until a couple of hours later and the orders and consults were already in. Interview

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revealed MD #38 did not have any concerns related to the misidentification and care. About a week later, MD #38 stated, they received information on revising the record.

Interview with Director #44 on 09/22/2025 at 1545 revealed the process to be followed when a patient was incorrectly registered was for whoever identified the error to send an email to EMPI/Combine team, a corporate team that managed these types of errors. Interview revealed the team was available from 0600 in the morning to about 0100 (unavailable approximately 5 hours each weeknight). Once the EMPI/Combine team got the notification email, they reviewed and would reach back out to the requestor with any questions. Interview revealed Director #44 did not receive e-mails sent to the Combine team. In this particular case the Director received a call from the patient's family voicing concerns and Director #44 got involved. After the medical record was combined, Director #44 reached out to clinical leaders until all notes in the medical record had been reviewed and corrected.

Interview on 09/23/2025 at 1425 with ED Manager #39 revealed that when the manager arrived to work around 0600 on 08/19/2025, and the issue related to the patient and misidentified name had not been corrected. Interview revealed a message had gone to the combine team earlier and the manager tried sending the information to them again. Later in the day it was still unresolved and Manager #39 escalated it, first to the House Supervisor, then the ED Director. At 1700, the VP was notified, who immediately escalated it farther and it got resolved. Manager #39 stated both charts were up and working, the charts just needed to be merged. Interview further revealed

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A 144	Continued From page 25 that Manager #39 did not know the processes that were being followed at the time. Telephone interview on 09/23/2025 at 1510 with RN #40 revealed when RN #40 came on duty at 1500, there was a patient with 2 charts, Pt #24. The orders and Medication Administration Record (MAR) remained in the incorrect record. There were no medication orders or MAR under the correct patient named record. The patient had a corrected ID bracelet on but could not scan the bracelet because the orders were in the incorrect record. RN #40 needed to give medications to Pt #24 so the nurse had a second RN verify the medication to ensure it was correct. Interview revealed RN #40 documented the medication in the MAR of the incorrect record with the note of a second verifier. In the correct patient record, interview revealed, the RN wrote a nursing note indicating medication was administered and called the hospitalists who said they would put orders in the correct chart.	A 144		
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, video monitor review, CMU (Central Monitoring Unit) documentation, hospital documents 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	A 385		

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A 385	Continued From page 26 place to supervise and provide safe delivery of care to patients for 5 of 32 records reviewed (Pts #14, #10, #34, #17, #15). . The findings included: 1. The hospital failed to ensure adequate staff was available to assess and respond to a monitored telemetry patient with leads off and the patient subsequently expired for 1 of 32 patients reviewed (Patient #14). Cross refer to 482.23 Nursing Standard: Tag A 0392. 2. Nursing staff failed to supervise and monitor care by failing to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport (Pt #10) and failing to prevent and control infections. Nursing staff failed to identify and communicate accurate and timely COVID precautions on an inpatient unit creating an unsafe environment for patient care (Pt #34) and exposure to COVID. Cross refer to 482.23 Nursing Standard: Tag A 0395 3. Hospital nursing staff failed to follow policies to evaluate a patient's change in condition requiring emergent treatment for 1 of 32 sampled patients (#17) and failed to follow post procedure guidelines following a heart catheterization for 2 of 32 sampled patients (#17, #15) .. Cross refer to 482.23 Nursing Standard: Tag A 0398	A 385		
A 392	STAFFING AND DELIVERY OF CARE	A 392		

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A 392	Continued From page 27 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 review of hospital policies and procedures, closed medical records, video review, the facility investigation, CMU (Central Monitoring Unit) documentation, and staff interviews, the hospital failed to ensure adequate staff was available to assess and respond to a monitored telemetry patient with leads off and the patient subsequently expired for 1 of 32 patients reviewed (Patient #14). The findings include: Review of hospital policy titled "Physiologic Monitoring - Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring" last approved 06/04/2025 revealed " ...PURPOSE ... C. Identify which rhythms or arrhythmias require RN (registered nurse) notification/intervention and identification of proper escalation procedures ...ALARM RESPONSE AND ESCALATION PROCESS A. ...a defined escalation pathway is used to ensure timely notification and treatment ...II. Rhythm Transmitting with ...Leads Off ... A. First Escalation Attempt: 1. MTII (monitor tech) calls Primary Nurse. 2. Within 5 minutes the Primary Nurse will assess the patient and call the monitor tech and give an update ...4. The MTII records the notification ... B. Second Escalation	A 392		

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Attempt: 1. If unable to reach Primary Nurse or unresolved within 5 minutes from the time of initial notification, the MTII call the Primary Nurse again and enter notification time ... C. Third Escalation Attempt: 1. If unable to reach Primary Nurse, or unresolved after 5 minutes, the MTII will call the CNC (clinical nurse coordinator)/Relief Charge Nurse. 2. If no resolution after 1 minute, send broadcast to unit. 3. If no resolution after 2 minutes, start escalation over until resolved.

Review of hospital policy titled "Assessment and Reassessment" last approved 05/13/2025 revealed "Purpose The organization assesses and reassess the patient and the patient's condition according to defined timeframes ... Policy ... C. The assessment process is a continuous, collaborative effort with departments functioning as an interdisciplinary team ... Assessment Framework A ...2. As individual patient condition changes ... Interdisciplinary Plan of Care (IPOC) ...D. Nursing maintains the responsibility and accountability ..."

Review of hospital document titled "ADULT INTERMEDIATE CARE STANDARDS OF CARE GUIDELINES-NURSING", revealed " ...Reassessment intervals and parameters are presented as the minimum times, measurements, and evaluation criteria ... Patient Rounding A. Safety Rounds to occur as recommended - every 1-2 hours ... Safety A. The patient can expect appropriate safety precautions while in the hospital ..."

Closed medical record review revealed Patient (Pt) #14 was a 72-year-old male readmitted on 07/23/2025 at 1715 for shortness of breath and chest pain. At 1742 there was an order for

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telemetry monitoring. Per documentation the patient was placed on telemetry and telemetry tech was notified. On 07/26/2025 at 0021 vital signs revealed temperature 98.1 (oral), heart rate (HR) 76, blood pressure (BP) 99/57, (oxygen saturation) SpO2 93% on 60L (liters) oxygen (O2) high flow humidified. At 0320 the (registered respiratory therapist) RRT documented the patients HR 78, respirations (RR) 18, SpO2 93% on 60L O2 high flow humidified. Review of a Provider Note at 0415 revealed "CODE BLUE called overhead on this patient ... Was not notified by staff of any issues overnight or notified of patient being found on the floor prior to CODE BLUE being called. CPR was in progress when I walked in the room. Per the patients nurse, he was found on the floor without his Vapotherm (high flow humidified O2) on and without telemetry on for an unknown period of time ... During discussion with Dr. (named) it was decided to stop the code as we never obtained a pulse. Time of death was called at 0403 ..." Review of the Code Blue documentation revealed code time started at 0347, the patient was intubated at 0354, and the code stopped at 0403. Record review failed to reveal that a bed/chair alarm was documented on the evening shift of 07/25/2025.

Review of video footage dated 07/26/2025 revealed footage of unit 4 heart. Review revealed a view of the nursing station, a hallway view of Patient #14's room (E433). From 0012 through 0024 staff were noted to be in Patient #14's room and the 2 staff members exited at 0024. At 0231 a female staff (identified as CNC #14) was seen sitting at the nurse station computer. At 0305 a male staff (identified as [registered respiratory therapist] RRT #21) entered the patient's room

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and was seen exiting the room also at 0305. At 0313 CNC #14 still observed at nurse station, observed answering the desk phone. At 0322 CNC #14 left the nurse station and walked to another patient's room. At 0346 male staff (identified as unit PCT) entered Patient #14's room. At 0348 the code team arrived via stairwell. Review did not reveal any nursing staff in Patient #14's room between 0024 and 0346, only the Respiratory Therapist at 0305.

Review of the facility investigation on 09/18/2025 at 1535 with Director #13, Director #9, and Nurse Administrative Staff (AS) #6 revealed a timeline of events. The timeline revealed on 07/25/2025 at 1900 an RN rounded on the patient and noted no distress. On 07/26/2025 at 0012 staff were in the patient's room. At 0242 the RN was notified by the CMU tech (central monitoring unit technician) that the telemetry leads were off. At 0244 the RN was notified by the CMU tech again. At 0305 the RRT rounded on the patient and noted no distress. At 0309 the CMU tech sent a text to the RN. At 0312 the CMU tech notified the CNC to reinforce the leads. At 0317 the CMU tech called the RN but did not get an answer. At 0320 the RRT documented HR 78, RR 18, SpO2 93%, Vapotherm at 60L/minute. At 0326 CMU tech called the CNC. The CNC told the CMU tech they were in a rapid response and would get to the patient after they transferred the rapid response patient off the unit. At 0341 the CMU tech reached out to the PCT (patient care technician) asking for the telemetry leads to be checked. At 0345 the PCT entered the room and found the patient on the floor. At 0347 a Code Blue was initiated. At 0354 the patient was intubated. At 0403 the Code ended. Further interview revealed that the RRT was interviewed after the incident.

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The RRT entered the patient's room at 0305 the RRT noted the patient was resting and did not have his telemetry leads on. The RRT used his pocket pulse oximetry to assess the patients SpO2 and noted the RRT had no issues and that he assumed the RN was aware of the leads being off and would get to them. Interview revealed that the CMU tech was interviewed after the incident. The CMU tech revealed that the RN stated someone would get to the patient, so the CMU tech was giving the RN the benefit of the doubt.

Review of CMU tech documentation on 07/26/2025 revealed at 0242 the RN was notified leads were off. At 0309 "called no answer left text". At 0312 RN notified. At 0326 "called rn [sic] she said we will get pt we are transporting right now." Per an interview with AS #6 the CMU tech did not write down all communication between the RN and CMU tech.

Interview on 09/18/2025 at 1020 with AS #6 revealed that the CMU techs have different escalation pathways to follow depending on the situation. Interview revealed that when all the leads were off the patient needs to be evaluated by the primary RN/nursing staff. When there was no resolution by nursing staff the CMU tech should reach out to the CNC. If no resolution, then the CMU tech calls an overhead telemetry alert page throughout the specific unit. The escalation process should be repeated until there was a resolution. The expectation of the overhead call was for all staff to respond. Interview revealed that on 07/26/2025 the CMU tech reached out to the RN and CNC but they were busy with another rapid response patient. Interview revealed when there was no resolution the CMU tech did not follow the escalation

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pathway and call overhead, nor did the RN delegate the responsibility to get the patient assistance.

Interview on 09/22/2025 at 1415 with CNC #14 revealed the CNC recalled the patient and incident. Interview revealed that the CNC was not aware that the patient was off telemetry until CMU called the CNC and by that time the CNC was in the rapid response. The CNC stated that she informed CMU they were in a rapid response and to call overhead and CMU said ok, but the CNC did not recall if that happened. The CNC stated she was not aware that CMU had been calling the primary RN because the RN didn't tell the CNC or delegate someone to check on the patient. Interview revealed that on the (named) unit all the RNs are paired with a buddy and that the primary RN should have called the buddy to check the patient. The CNC stated that the RN buddy was not in the rapid response and should have been available. Interview revealed that telemetry monitors can also be seen at the nurse station. The CNC did not recall any unit staff member on 07/26/2025 mention seeing the patient in E433 off of his telemetry monitor. Interview revealed that during the Code Blue debrief the RRT mentioned he told someone about the patient leads being off, but the CNC was not aware of the RRT alerting anyone. Further interview revealed that during the day shift rounding should take place every hour, and overnights between 10pm and 6am, the patient should be rounded on every two hours by either the RN or PCT. Interview revealed that the staffing ratio on the unit was one RN to five patients. On 07/26/2025 the CNC recalled that none of the RNs had more than five patients. Interview revealed that although the staff were within ratio the CNC felt the unit still had a staffing

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A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on policy review, observation, medical record review and staff and provider interviews, nursing staff failed to supervise and monitor care for 2 of 32 patients reviewed by failing to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport (Pt #10) and failing to prevent and control infections. Nursing staff failed to identify and communicate accurate and timely COVID precautions on an inpatient unit creating an unsafe environment for patient care (Pt #34) and exposure to COVID. The findings include: 1. Review of hospital policy, "Physiologic Monitoring - Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring - 1PC.NRS.0001," effective 08/19/2025, revealed, " ... III. Transport of Monitored Patients. 1. Interruption in cardiac monitoring should not occur during transport for patients with active orders for telemetry monitoring. a. Patients with active monitoring orders should continue to be remotely monitored, and the Monitor/Telemetry Technician should be notified of unit travel, destination, primary contact for duration of travel, and anticipated time of return ..."	A 395		

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Review of hospital policy, "Assessment and Reassessment, 1PC.ADM.0013," effective 05/13/2025, revealed, " ... 6. The interdisciplinary team provides information concerning patient assessment relevant to their scope of care, as well as areas of concern or patient special needs. Further assessment and reassessment is based on their plan of care or changes in their condition ... Reassessment may be at specified/regular intervals, triggered by key decision points, and at any interval(s) specified by the departments/ancillary disciplines directly involved in providing patient treatment and/or care ..."

Review of hospital Guidelines for Patient Transport revealed, " ...If a patient's condition appears to be questionable, always let the nurse know that you are non-clinical staff and ask if they feel that it is safe for you to transport the patient ..."

Observation of a patient elevator from the Emergency Department (ED) to a Stepdown unit on 09/19/2025 at 1345 revealed an alarm button in the elevator which rang only in the immediate elevator area. Observation revealed a red phone button in the elevator; an operator answered after approximately 45 seconds and asked if assistance was needed.

Observation of the Emergency Department (ED) on 09/23/2025 at 1159 revealed a patient was switched from ED telemetry monitoring to the CMU (Central Monitoring Unit) for monitoring during transport to inpatient holding. Observation revealed the portable telemetry box did not display a visual or have an audible alarm for any changes during transport.

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Closed medical record review on 09/17/2025 for Patient #10 revealed a 48-year-old presented to the Emergency Department (ED) on 09/04/2025 at 1441 with complaints of chest pain and shortness of breath. The patient's pain was documented at 1442 as 8 out of 10. The Provider's MSE (Medical Screening Exam) Note at 1445 revealed, "Patient with chest pain and shortness of breath. On home oxygen normally. chest tube in place. Patient is alert, in no acute distress but is moaning in discomfort." The patient's oxygen saturation (O2 sat) at 1446 was 97% and at 1500 was 90%. The ED Provider's Note at 1534 revealed the patient had a history of metastatic lung cancer with a chest tube on the right with "chronic pain at the tube site now with worsening shortness of breath for the past day." The patient's O2 sat at 1630 was 92%, and the patient was placed on 3 liters of oxygen via nasal cannula. The patient's O2 sat at 1715 was 93%. An order for Morphine (a pain medication) 4 milligrams IV (intravenous) was placed at 1729. An order was placed at 1731 for continuous pulse oximetry (measures how much oxygen is in the blood for uninterrupted periods). The patient's O2 sat at 1745 was 89% and at 1750 was 90%. A broadcast notification was sent to the Stepdown unit at 1803 with the room number the patient was assigned to and the box number for continuous pulse oximetry. The patient's blood pressure at 1807 was 84/57 with a comment by the Nurse that the Provider was notified at that time. The patient's pain was assessed at 1808 as 10 out of 10. A comment was documented on the MAR (Medication Administration Report) at 1809 that Morphine was not given as the patient's blood pressure was "too low to administer," and the Provider was notified. The patient's oxygen was increased to 4 liters at 1820 with an O2 sat

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of 94%. ED Nurse Note at 1830 revealed the patient was transported by transport staff. The patient was on an "O2 monitor, awake and alert. Prior to patient leaving emergency department this RN (Registered Nurse) spoke with transport leadership regarding blood pressure parameters for transport personnel. Transport leadership stated, 'We do not have parameters for blood pressure as long as you feel patient is stable for transport' ..." The patient's O2 sat prior to transport at 1830 was 93%. Record review failed to reveal documented evidence of the patient's heart rate and O2 sats during transport and failed to reveal documented evidence of the patient's time of arrival to the unit and initial O2 saturation on the unit. Review of a Code Record revealed a code blue (the initiation of resuscitative efforts in a cardiac or respiratory arrest) was called with initiation of CPR (cardiopulmonary resuscitation) at 1842 and initial ECG (electrocardiogram, a noninvasive test that records the electrical activity of the heart) rhythm of asystole (no heartbeat). Check boxes for the initial condition were selected as "Yes" for conscious, breathing, and pulse, as well as "Witnessed Arrest." A check box for "Monitored" was selected "No." The patient was intubated at 1853, and a rhythm of PEA (Pulseless Electrical Activity, a condition where the heart is still producing electrical signals, but there is no pulse or blood pressure) was noted at 1901. Discharge Summary dated 09/06/2025 at 2226 revealed the patient was admitted to a medical floor for further evaluation and management of acute respiratory failure. The patient "coded as soon as she transferred to the medical floor ..." and was pronounced dead at 1907 on 09/04/2025.

Interview on 09/18/2025 at 1335 with RN #26

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revealed Patient #10 was transported from the ED and was brought to their assigned room. Interview revealed Staff #7 called for help, because "something did not look right." A Nurse in the hallway responded and hit the Staff Assist button in the room, which sent an overhead alarm and blinked red outside the room. RN #26 responded at that time and observed the patient on the stretcher, and the patient appeared to be having seizure-like activity. The patient had their head back and was convulsing. RN #26 revealed the patient was moved to the bed, a code blue was called, and chest compressions were started immediately. Interview revealed Staff #7 reported the patient had been speaking to their family member in Spanish during transport, and when they arrived to the patient's room on the Stepdown unit, the seizure-like event occurred.

Telephone interview on 09/19/2025 at 0939 revealed nursing staff had "huge concerns" with signal loss in the elevators for their patients on remote telemetry.

Interview on 09/19/2025 at 1713 with Director #8 revealed Staff #7 reported RN #27 called the transport dispatch to ask if there were blood pressure parameters for transport and was informed there were not parameters for blood pressure. Staff #7 then transported Patient #10 to the Stepdown unit. When Staff #7 arrived to the unit, the Nurse was not in the patient's room, so Staff #7 pressed the call bell to alert the Nurse the patient had arrived. Interview revealed Patient #10 was in pain, so Staff #7 stepped out in the hallway to ask for help and a Nurse in the hallway responded. Staff #7 informed Director #8 that Patient #10's family was present, and assisted with translation from Spanish that the patient was

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in pain during transport.

Telephone interview on 09/22/2025 at 1422 with Staff #7 revealed Patient #10 had a family member with them at the bedside who assisted with translating from Spanish for Patient #10. Interview revealed Patient #10's family verified the patient's name and date of birth in English for Staff #7. Staff #7 revealed RN #27 asked if there were blood pressure parameters for transport, but Staff #7 was unaware of any parameters for blood pressure. Staff #7 called the transport dispatch, put them on speaker phone, and was informed there were not blood pressure parameters for transport. Transport dispatch informed RN #27 that the patient must be stable for non-clinical staff to transport; RN #27 checked the blood pressure again and signed off on Staff #7 transporting the patient. Staff #7 was not aware of any alarm that could be heard with the telemetry box during a patient's transport. Staff #7 revealed when they were in the elevator, the patient was moaning in pain and spoke in Spanish to their family. The family then translated in English to Staff #7 that the patient was in pain; Staff #7 reassured the patient and family that Staff #7 would get the patient help. Interview revealed when they arrived to the Stepdown unit, the patient was still moaning in pain, and the family asked, "Can you please help? You're a Nurse." Staff #7 informed the family they were not a Nurse but would get the patient help. Staff #7 noticed the patient showed signs of a seizure, and the family was "frantic, asking for help." Staff #7 pushed the Staff Assist button on the wall and stepped into the hallway for help. A Nurse approached and asked if they needed help, and then staff "were coming from everywhere into the room." Staff #7 then stepped out into the hallway,

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the stretcher was pushed out of the room, and Staff #7 was informed that they could leave.

Interview on 09/23/2025 at 0925 with RN #27 revealed Patient #10 had a significant other at the bedside, and RN #27 spoke in Spanish to them. RN #27 revealed the patient's blood pressure had dropped a little, and MD #28 had ordered fluids. Interview revealed the patient's blood pressure was not "at standard to give" Morphine. RN #27 revealed the patient was complaining of pain in the ED; RN #27 explained to the patient and their significant other that RN #27 could not give Morphine due to their blood pressure. Interview revealed the patient complained of generalized pain and stated, "everywhere hurts." Interview revealed RN #27 called the CMU prior to Staff #7 transporting the patient to ensure the CMU could visualize Patient #10 on their O2 monitor. The CMU verified visualization and provided the patient's heart rate and O2 sat. RN #27 did not recall the exact values but stated they were within normal limits. RN #27 revealed the telemetry boxes for transport did not have an alarm.

Telephone interview on 09/23/2025 at 1313 with Tech #5 revealed they recalled RN #27 called to verify the pulse ox for Patient #10 could be visualized by the CMU prior to transport from the ED to a Stepdown unit. Interview revealed they were on the phone for a few minutes troubleshooting the pulse ox probe as there were issues with the signal going in and out. Interview revealed Wi-Fi connection issues, such as the signal cutting in and out, could occur when a patient was transported. Tech #5 revealed during Patient #10's transport, the signal was again cutting in and out, and there was not a solid reading. Tech #5 revealed there were drops in

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Patient #10's O2 sats, but they could not get a clear reading due to signal issues. Interview revealed the CMU pod was very busy that day as there were multiple patients being transferred and admitted, as well as multiple escalations at that time. Tech #5 revealed any time there were O2 sats dropping or signal loss, the monitor techs should notify the Nurse as soon as they see it with a resolution time of 5 minutes. Interview revealed the Stepdown unit was not notified that Patient #10's pulse oximetry had signal issues, a loss of signal during transport, or drops in the patient's O2 sats.
2. A tour of the pulmonary medical unit was conducted 09/18/2025 at 1320. Prior to tour hospital staff noted the unit had served at one time as a COVID unit. The staff stated there were currently no (zero) COVID patients on the unit. Observation during the tour revealed some patient rooms were labelled with contact precaution signs, including Pt #34's room. Observation did not reveal any signage for enhanced COVID precautions and hospital staff again indicated there were no current COVID patients on the area being toured.

Medical record review for Patient #34, an inpatient on the unit during tour, revealed Patient #34 arrived to the ED and was admitted 09/16/2025. Medical record review revealed Pt #34 was tested for COVID, among other infectious diseases, and the COVID PCR resulted postitive on 09/16/2025. Review confimed Patient #34 was COVID positive on 09/18/2025 at the time of the tour.

According to hospital data, fifteen staff were assigned or potentially exposed to COVID.

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Family interview 09/18/2025 indicated hospital staff failed to inform the family of a COVID positive PCR on 09/16/2025 and appropriate precautions until 09/18/2025.

Interview on 09/19/2025 at 1425 with Director #47 revealed the enhanced precaution sign was in place until the morning of 09/18/2025 when the order was cancelled in error. Interview revealed enhanced COVID precautions included a N95 respirator (protective device designed to achieve a very close facial fit and efficient filtration of airborne particles) among other protective devices.

Interview on 09/26/2025 at 1830 with Director #47 and Nursing Adminstrative Staff (AS) #46, revealed the signage error occurred due to a computer programming error where the isolation precautions were changed to contact based on a different positive result and overrode the enhanced isolation sign order. Interview revealed that should not have happened, the enhanced isolation precautions should have remained in place. The patient's nurse, interview revealed, acknowledged the computer order for contact precautions and removed an enhanced precaution sign, replacing it with a contact isolation sign. Interview revealed an infectious disease doctor came in later that day, noticed the discrepancy and reordered and implemented the enhanced COVID precautions.

In summary, there was no indication nursing staff were aware of a COVID positive patient on the unit before or during the observational tour since no one acknowledged a current COVID patient. There was no evidence nursing understood the need to question a change in the isolation

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A 395	Continued From page 42 precautions for a COVID positive patient. It was a physician who discovered and corrected the precautions.	A 395		
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 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 review of policy, medical records and staff and provider interviews, hospital nursing staff failed to follow policies to evaluate a patient's change in condition requiring emergent treatment for 1 of 32 sampled patients (#17) and failed to follow post procedure guidelines following a heart catheterization for 2 of 32 sampled patients (#17, #15) The findings include: 1. Review of hospital policy titled "Assessment and Reassessment" last approved 05/13/2025 revealed "Purpose The organization assesses and reassess the patient and the patient's condition ... Policy ... C. The assessment process is a continuous, collaborative effort ... Assessment Framework A ...2. As individual patient condition changes ...D. Nursing maintains the responsibility and accountability ..."	A 398		

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Review of policy on 09/25/2025 titled "Clinical Documentation" with revision date of 07/26/2024, revealed "Purpose: A. Provides guidelines for documentation of patient care, patient data, and patient outcomes within the electronic medical record, by members of the clinical team as indicated.... Clinical documentation should be: 1. Completed during or immediately after care is provided, if possible, but not to exceed end of shift.... Documentation is: ...2. Based on professional observation and assessment. 3. Individualized to identify problems and actions taken. 4. Based on the patient's current status...."

Closed medical record review on 09/15/2025 of Patient #17 revealed a 69 year old female transferred from an outside facility on 06/07/2025 at 1752 via EMS to be evaluated for "NSTEMI (Non ST elevation Myocardial Infarction--possible heart attack without ST elevation of the ST waves on the heart monitor) and SEPSIS" Patient arrived at the ED (emergency department) with complaints of nausea after a fall 2 days prior. Patient #17's past medical history included afib (atrial fibrillation--irregular rhythm of the heart with inadequate pumping) with ablation (procedure to attempt to place the heart in normal rhythm) and hypertension.

Review of the patient's medical record revealed on 06/09/2025 at 0740 vital signs were documented as HR 124 (elevated) Temperature 102 (elevated), oxygen at 2 liters with pulse Oximetry at 90% (normal is 90 or above). At 0743, an order for an EKG (Electrocardiogram--tracing of the heart rhythm) was received from MD #45. At 0750 Tylenol was administered for elevated temperature by RN #25. At 0753, the EKG was completed. The

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results of the EKG were: "ST elevation more prominent. Sinus tach (tachycardia--fast heart rate) with occasional PVCs (premature ventricular contractions--abnormal rhythm). Old MI (myocardial infarction--heart attack). Abnormal EKG." Review of a communication from the Central Monitoring Unit (CMU) dated 06/09/2025 at 0758 revealed, "getting EKG per (RN #25). Freq (frequent) atrial and ventricular ectopy (irregular heart rhythm). The RN daily shift assessment was completed at 0800 by RN #25, noting "CV (cardiovascular) irregular. Diaphoretic." Review of the record revealed no evidence of notification to the physician regarding the EKG results. Review of the medical record, timed at 0840, revealed a Rapid Response was called (Rapid Response--emergency team to assist with patient's emergency). Review of a Rapid response note documented at 0840 stated: "Source of RRT (Rapid Response Team). Nurse request. Rapid response reason: Staff generalized concern. Husband requested the Rapid Response team be called. Increase in ST elevation. Noted elevated fevers decreasing plt (platelet) ct (count) down to 42 on a heparin (anticoagulant medication) gtt (drip) po (by mouth) ASA (Aspirin) given. Code STEMI (Process to alert emergency team to assist with heart attack patient.) ST elevation Myocardial infarction--heart attack with abnormal rhythm on the EKG) called and cath (Heart catheter department) lab at bedside to take pt (patient) to cath lab. We brought the husband to the cath lab waiting area." Review of the provider orders revealed at 0842 (two minutes after the rapid response was called), a cardiac cath was ordered by the Nurse Practitioner (NP #3). Patient #17 was taken to the cath lab for a cardiac catherization. Review of the record (nursing or

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progress notes) revealed no assessment of the patient's condition from the NP or nursing staff to describe the condition of the patient. The patient was taken to the cardiac cath lab at 0855. Review of the cardiac cath revealed "Pattern typical for Takotsubo cardiomyopathy (known as broken heart syndrome--a heart condition that causes a sudden weakening of the heart's pumping function). Review revealed no evidence of an assessment of the patient's change in condition or evaluation of the patient when the rapid response was called. Review revealed no notes from the nurses or provider during the rapid response.

Interview on 09/17/2025 at 1545 with RN #25, the patient's primary nurse, revealed there was no notification to the provider of the patient's EKG results and no documentation of the patient's change in condition. The nurse stated she would usually assess and document a patient's change in condition and abnormal results. The nurse was unable to remember the patient.

Interview on 09/18/2025 at 1115 with RN #2, Nursing Director, revealed no assessment or evaluation of the patient's change in condition or notification to the provider regarding the EKG results. Interview revealed the hospital policy was not followed.

Interview with NP #3 on 09/18/2025 at 1550 revealed NP #3 may have received a phone call for concerns about Patient #17, but did not recall. Interview revealed NP #3 did not have an explanation regarding the lack of documentation of assessment and treatment for Patient #17 during the Rapid Response.

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A 398	Continued From page 46 Interview on 09/18/2025 at 1600 with MD #1 revealed no assessment documentation from the NP was located in Patient #17's medical record. Interview on 09/18/2025 at 1215 with RN #2 revealed vital signs were not taken per policy. Interview revealed no documentation of the occlusive dressing being placed on the puncture site. Interview revealed policy was not followed. 2. Review on 09/16/2025 of Guidelines titled "Radial Compression Band (TR Band) Radial Compression Device Removal Guidelines" with a "Created" Date of "Feb 2018" revealed "For Diagnostic cases, the TR band should be left on with appropriate compression for 1.5 hours post procedure or as ordered by Physician....Assess and document vital signs, site condition, pulse, color, temperature, sensation, capillary refill q (every) 15 x 4 (4 times), q 30 x 2 (2 times), q hr x 4 (4 times). NOTE*While the TR band is in place, an oxygen saturation probe must be placed on the patient's thumb/pointer finger to monitor adequate hand perfusion .... REMOVAL PROCESS: 1. Once it is time to remove the TR Band, withdraw 3 ml (milliliter) of air over 1 minute observing for bleeding. Observe for additional 1 minute for bleeding after each 3 ml of air removed. Repeat every 10 minutes until band is fully deflated. Perform site condition, pulse, color, temperature sensation and capillary refill checks q 15 x 2. (In addition to post procedural vital signs) .... 2. Once TR band is completely deflated and homeostasis is maintained: Leave deflated band in place for 1 hour and continue to perform post procedure vital signs and site checks. Remove and discard TR band after 1 hour and place a protective covering (Tegaderm--clear occlusive dressing) over the	A 398		

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radial percutaneous site. Inpatients: continue to evaluate the site for bleeding/hematoma q 15 x 4, then per unit routine. 3. The patient should be instructed not to manipulate the wrist for 48 hours....."

2a. Closed medical record review on 09/15/2025 of Patient #17 revealed a 69-year-old female transferred from an outside facility on 06/07/2025 via EMS to be evaluated for "NSTEMI (Non ST elevation Myocardial Infarction--possible heart attack without ST elevation of the ST waves on the heart monitor) and SEPSIS." Patient #17 was sent to the Cardiac Catheterization Lab on 06/09/2025 at 0855 and returned to the patient's room at 0950. Review of documentation of the TR band revealed the TR band was placed on the patient at 0926. Vitals signs were documented every 15 minutes times 4 between 0945 and 1030. Assessment of the site condition, color, temperature, sensation and capillary refill was not documented every 15 minutes times four as the policy requires. Vitals signs were documented every 30 minutes times 2 at 1100 and 1130. Assessment of the site condition, color, temperature, sensation and capillary refill was not documented every 30 minutes times two as the policy requires. Vitals signs were not documented every one hour times 4 between 1230 and 1530. Vital signs due at 1330, 1430 and 1530 were not done as per the policy. Assessment of the site condition, color, temperature, sensation and capillary refill was not documented every one hour times four as the policy requires. The assessment was not documented at 1230, 1330, 1430 or 1530. Review of the removal of air from the TR Band started at 1200 with 4 milliliters (ml) of air removed (not consistent with the required 3 ml of

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air to be removed). There was no documentation of the observation for bleeding at the site for one minute after the air withdrawal. Three ml of air was due to be removed at 1210; however the air was removed at 1215 (not consistent with the policy); three ml of air was due to be removed at 1225; however no air was removed at 1225 (not consistent with the policy); three ml of air was due to be removed at 1235; however no air was removed at 1235 (not consistent with the policy);); three ml of air was due to be removed at 1245; however no air was removed at 1245 (not consistent with the policy);); three ml of air was due to be removed at 1255; however no air was removed at 1255 (not consistent with the policy); five ml of air was removed at 1300 (not consistent with the policy that requires only three ml of air to be removed). The TR Band was deflated at 1300. The policy requires the TR Band to remain in place for one hour after it is deflated with vital signs and site assessments to be assessed every 15 minutes times two. Vital signs and site checks were due at 1315 ad 1330. Review revealed the vital signs and site assessments were not done at 1315 and 1330 (not consistent with policy). Review of the record revealed no documentation of a site assessment through 2307 on 06/09/2025. Review of documentation of the TR Band revealed no documentation that an occlusive dressing on the puncture site was applied (not consistent with the policy). In summary, the vital signs and assessment of the puncture site were not completed as per policy. The TR Band was not deflated per policy. The occlusive dressing was not placed on the puncture site per policy.

Interview on 09/18/2025 at 1215 with RN #2 revealed vital signs and site assessments were

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not done per policy. Interview revealed the deflation was not done according to the policy. Interview revealed no documentation of the occlusive dressing being placed on the puncture site. Interview revealed the policy was not followed.

2b. Open medical record review on 09/18/2025 of Patient #15 revealed a 45-year-old male admitted on 09/13/2025 for chest pain after a fall. Patient #15's admitting diagnosis was NSTEMI, type I versus type II and ground level fall. Patient #15 was sent for a left heart cardiac catheterization on 09/15/2025 at 1508. Review of documentation of the TR band revealed the TR band was placed on the patient on 09/15/2025 at 1525. The TR Band was to remain in place one and one-half hours per policy before the air withdrawal process was to be started. The deflation was scheduled to start at 1655. Review of the record revealed the TR Band deflation was started at 1545 (20 minutes after the band was applied - not consistent with policy). Vital signs and site assessments were to be done every 15 minutes times four (due at 1525, 1540, 1555, and 1610). The patient's vital signs were not done per policy between 1525 and 1610.
The deflation started at 1545, and the patient was to have 3 ml of air removed every ten minutes until the TR Band was fully deflated per the policy. Three ml of air was due for removal at 1555, 1610 and 1620. Review revealed 3 ml of air was removed at 1600 (not consistent with policy), four ml of air was removed at 1615 (not consistent with policy). The TR Band was fully deflated at 1615. Per policy the TR Band should be left deflated for one hour (due to be removed at 1715). Per policy, vital sign assessments should be continued every 15 minutes times two. Vital

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A 398	Continued From page 50 signs were due at 1630 and 1645. Record review revealed vitals were documented at 1748 (not consistent with policy). The occlusive dressing was not placed on the puncture site per policy. Interview on 09/18/2025 at 1500 with RN #30 revealed the vital signs and deflation of the TR Band were not obtained according to policy. Interview revealed the occlusive dressing was not documented. Interview revealed the policy was not followed. An interview for the primary nurse was requested. An interview was not obtained.	A 398		
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 policies, medical records, and interviews with staff, the provider and nursing staff failed to document during a patient's change in condition for 1 of 1 patients who received a rapid response. (Patient #17). The findings include: Review of policy on 09/25/2025 titled "Clinical Documentation" with revision date of 07/26/2024, revealed "Purpose: A. Provides guidelines for documentation of patient care, patient data, and patient outcomes within the electronic medical record, by members of the clinical team as	A 449		

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indicated by scope of practice....General Information: A. Clinical staff have a professional obligation to maintain documentation that is timely, clear, concise, comprehensive, and that is an accurate source of information. Clinical documentation should be: 1. Completed during or immediately after care is provided, if possible, but not to exceed end of shift. 2. Completed by the clinical team/caregivers evidenced by signature for paper documentation or login for electronic documentation. 3. Factual, accurate and objective. 4. Prefaced with date and time of care to include recording of late entries, corrections or additions. B. Documentation is patient-centered, focused, and appropriate to the setting in which care is provided. Documentation is: ...2. Based on professional observation and assessment. 3. Individualized to identify problems and actions taken. 4. Based on the patient's current status and preferences...."

Closed medical record review on 09/15/2025 of Patient #17 revealed a 69 year old female transferred from an outside facility on 06/07/2025 via EMS (Emergency Medical Services--ambulance) to be evaluated for "NSTEMI and SEPSIS (Non ST elevation Myocardial Infarction--possible heart attack without ST elevation of the ST waves on the heart monitor)." Patient arrived at ED (Emergency Department) at 1752 with complaints of nausea after a fall 2 days prior. Patient #17's past medical history included afib (atrial fibrillation--irregular rhythm of the heart with inadequate pumping) with ablation (procedure to attempt to place the heart in normal rhythm) and hypertension.

1. Review of documentation of rapid response written by Rapid Response Nurse #29 on

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06/09/2025 at 0840 revealed "Source of RRT (Rapid Response Team) Activation: Nurse request. Rapid Response Reason for Call: Staff generalized concern. Husband requested the Rapid Response team to be called--increase in ST elevation--Noted elevated fevers decreasing plt (platelet) ct (count) down to 42 on a heparin gtt (drip) po (by mouth) asa (aspirin) given..Code stemi (st elevated myocardial infarction--heart attack) called and cath Lab at bedside to take pt to cath lab--We brought the husband to the cath lab waiting area." Review revealed no nurses notes of change in condition for Patient #17. Review revealed no nurses notes for rapid response team interventions.

Interview on 09/17/2025 at 1545 with RN #25 revealed there was no documentation of change in condition or notification of the provider.

Interview on 09/18/2025 at 1115 with RN #2 revealed no documentation of change in condition or notification of the provider. Interview revealed documentation was incomplete.

2. Review revealed an order written on 06/09/2025 at 0842 by NP (Nurse Practitioner) #3 for Cardiac Catheterization. Review revealed no provider notes or documentation of the change in condition of Patient #17. Review revealed no assessment from NP #3 of Patient #17.

Interview on 09/18/2025 at 1550 with NP #3 revealed NP #3 may have received a phone call for concerns about the Patient #17. Interview revealed no NP documentation of the assessment of Patient #17.

Interview on 09/18/2025 at 1600 with MD #1

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A 449	Continued From page 53 revealed no assessment documentation from the NP was located in Patient #17's medical record.	A 449		
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, internal document review, observation, closed medical record review, and staff interviews, the Emergency Department (ED) staff failed to have effective emergency services to meet the needs of patients that presented to the Emergency Department. The findings include: 1. The Emergency Department (ED) staff failed to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport from the ED to an inpatient unit for 1 of 12 ED patients reviewed (Patient #10). ~cross refer to 482.55 Emergency Services Standard: Tag 1103	A1100		
A1103	INTEGRATION OF EMERGENCY SERVICES CFR(s): 482.55(a)(2) [If emergency services are provided at the hospital --] (2) The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by:	A1103		

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Based on policy review, internal document review, observation, closed medical record review, and staff interviews, the Emergency Department (ED) staff failed to ensure safe and appropriate transport and continuous pulse oximetry monitoring for a patient during transport from the ED to an inpatient unit for 1 of 12 ED patients reviewed (Patient #10).

The findings include:

Review of hospital policy, "Physiologic Monitoring - Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring - 1PC.NRS.0001," effective 08/19/2025, revealed, " ... III. Transport of Monitored Patients. 1. Interruption in cardiac monitoring should not occur during transport for patients with active orders for telemetry monitoring. a. Patients with active monitoring orders should continue to be remotely monitored, and the Monitor/Telemetry Technician should be notified of unit travel, destination, primary contact for duration of travel, and anticipated time of return ..."

Review of hospital policy, "Assessment and Reassessment, 1PC.ADM.0013," effective 05/13/2025, revealed, " ... 6. The interdisciplinary team provides information concerning patient assessment relevant to their scope of care, as well as areas of concern or patient special needs. Further assessment and reassessment is based on their plan of care or changes in their condition ... Reassessment may be at specified/regular intervals, triggered by key decision points, and at any interval(s) specified by the departments/ancillary disciplines directly involved in providing patient treatment and/or care ..."

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Review of hospital Guidelines for Patient Transport revealed, " ...If a patient's condition appears to be questionable, always let the nurse know that you are non-clinical staff and ask if they feel that it is safe for you to transport the patient ..."

Observation of the ED on 09/23/2025 at 1159 revealed a patient was switched from ED telemetry monitoring to the CMU (Central Monitoring Unit) for monitoring during transport to inpatient holding. Observation revealed the portable telemetry box did not display a visual or have an audible alarm for any changes during transport.

Closed medical record review on 09/17/2025 for Patient #10 revealed a 48-year-old presented to the Emergency Department (ED) on 09/04/2025 at 1441 with complaints of chest pain and shortness of breath. The patient's pain was documented at 1442 as 8 out of 10. The Provider's MSE (Medical Screening Exam) Note at 1445 revealed, "Patient with chest pain and shortness of breath. On home oxygen normally. chest tube in place. Patient is alert, in no acute distress but is moaning in discomfort." The patient's oxygen saturation (O2 sat) at 1446 was 97% and at 1500 was 90%. The ED Provider's Note at 1534 revealed the patient had a history of metastatic lung cancer with a chest tube on the right with "chronic pain at the tube site now with worsening shortness of breath for the past day." The patient's O2 sat at 1630 was 92%, and the patient was placed on 3 liters of oxygen via nasal cannula. The patient's O2 sat at 1715 was 93%. An order for Morphine (a pain medication) 4 milligrams IV (intravenous) was placed at 1729. An order was placed at 1731 for continuous pulse

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oximetry (measures how much oxygen is in the blood for uninterrupted periods). The patient's O2 sat at 1745 was 89% and at 1750 was 90%. A broadcast notification was sent to the Stepdown unit at 1803 with the room number the patient was assigned to and the box number for continuous pulse oximetry. The patient's blood pressure at 1807 was 84/57 with a comment by the Nurse that the Provider was notified at that time. The patient's pain was assessed at 1808 as 10 out of 10. A comment was documented on the MAR (Medication Administration Report) at 1809 that Morphine was not given as the patient's blood pressure was "too low to administer," and the Provider was notified. The patient's oxygen was increased to 4 liters at 1820 with an O2 sat of 94%. ED Nurse Note at 1830 revealed the patient was transported by non-clinical transport staff. The patient was on an "O2 monitor, awake and alert. Prior to patient leaving emergency department this RN (Registered Nurse) spoke with transport leadership regarding blood pressure parameters for transport personnel. Transport leadership stated, "We do not have parameters for blood pressure as long as you feel patient is stable for transport ..." The patient's O2 sat prior to transport at 1830 was 93%. Record review failed to reveal documented evidence of the patient's heart rate and O2 sats during transport. Record review failed to reveal documented evidence of the patient's time of arrival to the unit and initial O2 sat. Review of a Code Record revealed a code blue (the initiation of resuscitative efforts in a cardiac or respiratory arrest) was called with initiation of CPR (cardiopulmonary resuscitation) at 1842 and initial ECG (electrocardiogram, a noninvasive test that records the electrical activity of the heart) rhythm of asystole (no heartbeat). Check boxes for the

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initial condition were selected as "Yes" for conscious, breathing, and pulse, as well as "Witnessed Arrest." A check box for "Monitored" was selected "No." The patient was intubated at 1853, and a rhythm of PEA (Pulseless Electrical Activity, a condition where the heart is still producing electrical signals, but there is no pulse or blood pressure) was noted at 1901. Discharge Summary dated 09/06/2025 at 2226 revealed the patient was admitted to a medical floor for further evaluation and management of acute respiratory failure. The patient "coded as soon as she transferred to the medical floor ..." and was pronounced dead at 1907 on 09/04/2025.

Interview on 09/18/2025 at 1335 with RN #26 revealed Patient #10 was transported from the ED and was brought to their assigned room. Interview revealed Staff #7 called for help, because "something did not look right." A Nurse in the hallway responded and hit the Staff Assist button in the room, which sent an overhead alarm and blinked red outside the room. RN #26 responded at that time and observed the patient on the stretcher, and the patient appeared to be having seizure-like activity. The patient had their head back and was convulsing. RN #26 revealed the patient was moved to the bed, a code blue was called, and chest compressions were started immediately. Interview revealed Staff #7 reported the patient had been speaking to their family member in Spanish during transport, and when they arrived to the patient's room on the Stepdown unit, the seizure-like event occurred.

Telephone interview on 09/19/2025 at 0939 revealed the Nursing staff had "huge concerns" with signal loss in the elevators for their patients on remote telemetry.

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A1103	Continued From page 58 Interview on 09/19/2025 at 1713 with Director #8 revealed Staff #7 reported RN #27 called the transport dispatch to ask if there were blood pressure parameters for transport and was informed there were not parameters for blood pressure. Staff #7 then transported Patient #10 to the Stepdown unit. When Staff #7 arrived to the unit, the Nurse was not in the patient's room, so Staff #7 pressed the call bell to alert the Nurse the patient had arrived. Interview revealed Patient #10 was in pain, so Staff #7 stepped out in the hallway to ask for help and a Nurse in the hallway responded. Staff #7 informed Director #8 that Patient #10's family was present and assisted with translation from Spanish that the patient was in pain during transport. Telephone interview on 09/22/2025 at 1422 with Staff #7 revealed Patient #10 had a family member with them at the bedside who assisted with translating from Spanish for Patient #10. Interview revealed Patient #10's family verified the patient's name and date of birth in English for Staff #7. Staff #7 revealed RN #27 asked if there were blood pressure parameters for transport, but Staff #7 was unaware of any parameters for blood pressure. Staff #7 called the transport dispatch, put them on speaker phone, and was informed there were not blood pressure parameters for transport. Transport dispatch informed RN #27 that the patient must be stable for non-clinical staff to transport; RN #27 checked the blood pressure again and signed off on Staff #7 transporting the patient. Staff #7 was not aware of any alarm that could be heard with the telemetry box during a patient's transport. Staff #7 revealed when they were in the elevator, the patient was moaning in pain and spoke in	A1103		

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Spanish to their family. The family then translated in English to Staff #7 that the patient was in pain; Staff #7 reassured the patient and family that Staff #7 would get the patient help. Interview revealed when they arrived to the Stepdown unit, the patient was still moaning in pain, and the family asked, "Can you please help? You're a Nurse." Staff #7 informed the family they were not a Nurse but would get the patient help. Staff #7 noticed the patient showed signs of a seizure, and the family was "frantic, asking for help." Staff #7 pushed the Staff Assist button on the wall and stepped into the hallway for help. A Nurse approached and asked if they needed help, and then staff "were coming from everywhere into the room." Staff #7 then stepped out into the hallway, the stretcher was pushed out of the room, and Staff #7 was informed that they could leave.

Interview on 09/23/2025 at 0925 with RN #27 revealed Patient #10 had a significant other at the bedside, and RN #27 spoke in Spanish to them. RN #27 revealed the patient's blood pressure had dropped a little, and MD #28 had ordered fluids. Interview revealed the patient's blood pressure was not "at standard to give" Morphine. RN #27 revealed the patient was complaining of pain in the ED; RN #27 explained to the patient and their significant other that RN #27 could not give Morphine due to their blood pressure. Interview revealed the patient complained of generalized pain and stated, "everywhere hurts." Interview revealed RN #27 called the CMU prior to Staff #7 transporting the patient to ensure the CMU could visualize Patient #10 on their O2 monitor. The CMU verified visualization and provided the patient's heart rate and O2 sat. RN #27 did not recall the exact values but stated they were within normal limits. RN #27 revealed the telemetry

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boxes for transport did not have an alarm.

Telephone interview on 09/23/2025 at 1313 with Tech #5 revealed they recalled RN #27 called to verify the pulse ox for Patient #10 could be visualized by the CMU prior to transport from the ED to a Stepdown unit. Interview revealed they were on the phone for a few minutes troubleshooting the pulse ox probe as there were issues with the signal going in and out. Interview revealed Wi-Fi connection issues, such as the signal cutting in and out, could occur when a patient was transported. Tech #5 revealed during Patient #10's transport, the signal was again cutting in and out, and there was not a solid reading. Tech #5 revealed there were drops in Patient #10's O2 sats, but they could not get a clear reading due to signal issues. Interview revealed the CMU pod was very busy that day as there were multiple patients being transferred and admitted, as well as multiple escalations at that time. Tech #5 revealed any time there were O2 sats dropping or signal loss, the monitor techs should notify the Nurse as soon as they see it with a resolution time of 5 minutes. Interview revealed the Stepdown unit was not notified that Patient #10's pulse oximetry had signal issues, a loss of signal during transport, or drops in the patient's O2 sats.

In summary, Patient #10, a 48-year-old, presented to the Emergency Department (ED) on 09/04/2025 at 1441 with complaints of chest pain and shortness of breath. The patient experienced 10 out of 10 pain at 1808 and was unable to receive Morphine due to low blood pressure (84/57). The patient was admitted and transported to a Stepdown unit by a nonclinical transporter at 1830 with an order for continuous

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A1103	Continued From page 61 pulse oximeter. Findings revealed the pulse oximeter did not have continuous signal once the patient left the ED with a drop in oxygen saturation noted. The patient was moaning in pain and requesting nursing help during transport. The patient arrived to the unit, was transported to their room, observed to have seizure-like activity, and a code blue was called at 1842 (12 minutes after departing the ED). The patient expired at 1907. Emergency Department staff failed to ensure a patient with pain and shortness of breath was safe and appropriate for transport and continuously monitored prior to departing the ED. NC00233618, NC00233522, NC00233506, NC00233502, NC00233485, NC00233465, NC00233454, NC00233389, NC00233322, NC00233369, NC00233275, NC00233182, NC00233099, NC00233082, NC00233077, NC00232951, NC00231722, NC00231945, NC00231715, NC00231472	A1103		