

My mother was hospitalized at Charleston Area Medical Center in West Virginia on September 1, 2021, after a fall at home and critically low oxygen levels. We were told she tested positive for COVID-19, but received very limited information about her injuries or condition. Her records later showed three COVID tests, a “presumptive positive” added later, and documentation that she had stabilized by midday.

During the first several days, my sister and I repeatedly called the hospital for updates and provided multiple contact numbers, yet communication remained extremely limited. A cardiologist documented concern for anoxic encephalopathy from oxygen deprivation and noted neurology was available if needed, but I found no documentation that neurology ever evaluated her.

My father was told he could not see his wife unless he was fully vaccinated, despite having already recovered from COVID-19. He was **required to receive two COVID vaccinations** before being permitted to visit her. This delayed his access and limited our ability to advocate for her care. When we requested alternative treatments, those requests were denied.

Records show comfort-care measures beginning September 8, yet our family was **never notified** her care plan had been changed or given an opportunity to consent. Her medical records document that my mother repeatedly said she wanted to go home. When staff called, they did not tell us this. Instead, we were told they planned to transport her home, remove the high-flow oxygen, and **allow her to die**. We were never offered the option of providing high-flow oxygen or BiPAP at home.

My father was able to see my mother the day before she died. She told him she was hungry and thirsty and **that staff would not give her water**. When he tried to bring her water, staff objected and required him to keep it out of her reach. She was unable to eat or drink and could not reach her phone to contact family. She also told him she wanted to go home, have her hair washed, and see her dogs.

When she became distressed and he begged staff to help her, a nurse pulled off her oxygen mask, leaving her gasping for air, and told him, **“Shut up, old man. We don’t need your permission.”** This was reported to us directly by my father and remains one of the most disturbing parts of her final hours. We later learned that the nurse involved received a **Heart and Soul Award** from the hospital, which compounded our grief given the circumstances.

On September 10, notes document calls with me, my sister, and then my father, her legal next of kin. We were told she was unstable and being given medication that “could go either way,” yet the record stated “no change in previous assessment,” with oxygen saturation documented at 88 percent.

Her medication record shows morphine at 9:38 a.m.; morphine, lorazepam, and Robinul at 10:02 a.m.; her legal time of **death recorded at 10:21 a.m.**; then morphine documented as “administered” at **10:32 a.m.**, eleven minutes after her death; and the same medication charted

at **11:44** a.m., eighty-three minutes after her death. She was also given **morphine** despite a documented **codeine allergy**.

We found multiple consent forms for comfort-care measures, including one dated after her death. None of the signatures resemble my mother's. The emergency room documented on September 1 that she was **incapable of making her own medical decisions**, and that designation was never updated. One consent form was dated five days after her death and **one day after she was buried**.

In our family's experience, a woman who fell at home was isolated, family was required to have vaccinated visitors, documented as incapable of medical decision-making, yet shown as signing end-of-life consents, including one dated after her burial. Medication was documented after her legal time of death, and her legal next of kin was never notified of comfort-care. These contradictions are why we request an independent review of her care, documentation, and consent process.