STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150166	A. BUILDING 00 B. WING	10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HOSPITAL	9301 CONNECTICUT DR CROWN POINT, IN46307

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A0000	This visit was for a recertification survey. Facility Number: 006619 Survey Date: 10/04-05/2011 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Lynnette Smith, Laboratorian/ Medical Surveyor	A0000		
A0083	QA: claughlin 10/25/11 The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. Based on document review and staff interview, the facility failed to demonstrate quality monitor indicators for 3 of 11 contracted services.	A0083	On November 9, 2011, Pinnacle drafted Policy A-23 governing contractor services, including Physical Therapy Services and Mobile Services,provided in the hospital to ensure that as part of Pinnacle's QAPI program a Qualified Individual shall assess	11/09/2011

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

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	Findings: 1. Document review of the hospital quality monitor indicators on October 5, 2011 at 1pm indicated three contracted services were not included in the monitor: Housekeeping; Rehab Services; and Mobile Services. 2. Interview with Employee #A2 and Employee #8 on October 5, 2011 at 1pm verified these findings.		that services furnished by hospital staff and services provided under contract comply with all applicable state and federal rules and regulations. On November 18,2011, the Governing Board of Pinnacle shall approve this policy. This policy is attached as Exhibit 1. Per the policy, the appropriate department manager is responsible for evaluating the service provided. A copy of the report is forwarded to the Quality Assurance Department on a quarterly basis with the department's performance improvement report and the department manager will provide a report to the Utilization Review/Quality Assurance/Risk Management Committee along with the scheduled department performance improvement report. Specifically for Mobile Services, the QAPI monitor is designed to assure that the exam that is being scanned by the MRI technologist follows the Pinnacle Radiology department's expectation. The Quality Management Team will randomly select 5 exams per month to monitor all pertinent information with regards to the technological factors selected by the technologist to make sure it is consistent with Pinnacle's protocols. The Medical Director of Radiology will supervise the QI monitor along with the MRI Technologist. Attached as Exhibit 2 is the Mobile MRI QI Monitor Log. Attached as Exhibit 3 is the	

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			Physical Therapy and Occupational Therapy QI Monitor Log. Please note, that Housekeeping Services are not provided through contract, thus these services should not have been cited by the Surveyor. **Addendum-The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	
A0409	Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures. If blood transfusions and intravenous medications are administered by personnel other than doctors of medicine or osteopathy, the personnel must have special training for this duty. Based on review of policies and procedures, patient records, and staff interview, nursing services failed to ensure blood transfusions were administered in accordance with approved policies and procedures for 6 of 8 patient records reviewed. Findings included: 1. Review of policies and procedures on 10-5-11 between 11:10 AM and 11:30 AM revealed a policy/procedure titled: Blood, Blood Products, Derivatives Administration", policy number: "PCS B-8", last revised "10/09", which read:	A0409	On November 9, 2011 the Blood Cooler Log was revised to ensure that blood transfusions are administered in accordance with Pinnacle's policies and procedures. The Nurse is required to record the time blood units are removed from the cooler. Nurses were educated about this new log on November 9, 2011. The revised log and meeting minutes from the education session is attached as Exhibit 4. On November 18, 2011, the Governing Board of Pinnacle shall approve this revised log. The Quality Management Team will review every blood cooler log to help ensure compliance Pinnacle's policies and procedures. If the	11/09/2011

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	"Packed cells/blood..never exceed 4 hours from the time the bag is taken out of the validated cooler..." and "Blood transfusion must must initiated within thirty minutes from the time the bag is removed from the validated cooler..." and "Assess vitals (T,P, and B/P) within 1 hour prior to administration and sign record." and "Reassess vitals (T,P, B/P)...fifteen minutes after "start time" (plus or minus 5 minutes is acceptable)..." 2. Review of patient records on 10-5-11 between 12:15 PM and 2:35 PM revealed the following: a. Patient #L1 was admitted on 7-6-11 and discharged on 7-8-11. The patient received 2 units of leukoreduced packed red blood cells (LR PRBC). The first transfusion was initiated on 7-7-11 at "1130 AM" and the second transfusion was initiated at "1325" on the same date. The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes from the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. b. Patient #L2 was admitted on 9-12-11 and discharged on 9-13-11. The patient received 2 units of LR PRBC's.		Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant staff. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a quarterly basis. **Addendum-The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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	The first transfusion was initiated on 9-13-11 at "0140" and fifteen minute vital signs were taken at "0140", the same time the transfusion was initiated. The second transfusion was started at "0520" on the same date. The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes from the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. c. Patient #L4 was admitted on 6-8-11 and discharged on 6-8-11. The patient received 2 units of LR PRBC's on 6-8-11. The first transfusion was initiated at "1359" and the second transfusion was initiated at "1406". The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. d. Patient #L5 was admitted on 5-13-11 and discharged on 5-16-11. The patient received 2 units of LR PRBC's. The first transfusion was initiated on			

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	5-14-11 at "1045" and the second transfusion was initiated on 5-15-11 at "0045". The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. e. Patient #L7 was admitted on 3-29-11 and discharged on 4-7-11. The patient received one unit of LR PRBC's on 3-30-11, which was initiated at "1712". The time the unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusion was initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. f. Patient #L8 was admitted on 9-22-11 and discharged on 9-26-11. The patient received one unit of LR PRBC's on 9-25-11, which was initiated at "1738." The time the unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusion was initiated with 30 minutes for the time the blood			

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	was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. 3. In interview on 10-5-11 between 1:20 PM and 2:35 PM, Staff Member #L11 acknowledged the above findings and conveyed the facility did not document the time units of blood were removed from the validated coolers.			
A0466	[All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. Based on document review, policy and procedure review, medical record review, and staff interview, the facility failed to ensure a properly executed informed consent form was in the patient's chart as required per facility policy and procedure for 11 of 22 (N2, N3, N4, N8, N13, N15-N17, and N19-N21) closed patient medical records reviewed. Findings: 1. Review of Medical Staff Rules and Regulations on 10/5/11 at 11:00 AM, indicated on pg. 12, point 18., "All clinical entries shall be dated, timed and authenticated..."	A0466	A memo was sent on November 4, 2011 to all Pinnacle Surgeons educating the surgeons about the policies and Hospital bylaw provisions in regard to physician signatures,dates and times of authentications. The materials provided informed surgeons of the need for signature and time to be documented on the Consent for Operative or Diagnostic Procedures. The memo sent is attached as Exhibit 5. Signs are being posted in the PACU area, the physician's lounge, and the inpatient unit reminding surgeon's of this requirement. Further, a memo was sent on November 4, 2011 to all Pinnacle Anesthesiologists and CRNAs in regards to Pinnacle's policies on	11/04/2011

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	2. Policy titled, "Consent to Operation and Anesthesia Services" reviewed on 10/5/11 at 10:34 AM, indicated on pg. 1, under Procedure section, points 1.D. & E., "All blanks on the consent form must be filled in. If the item is not-applicable, place N/A in the blank and/or draw lines to fill in the blank...The patient must sign the consent before he receives a sedative or mind-altering medication..." 3. Policy titled, "Surgical Consent" reviewed on 10/5/11 at 10:39 AM, indicated on pg. 1, under Procedure section, point 4., "Each patient will be provided with informed consent." 4. Review of closed patient medical records on 10/4/11 at 2:51 PM, indicated: a. N2 had a Consent for Operative or Diagnostic Procedures dated 4/20/11, but was lacking physician signature and time for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable." b. N3 had a Consent for Operative or Diagnostic Procedures dated 8/4/11 and: i. time of patient's authentication was lacking; ii. physician authentication was timed		Anesthesia consent. The memo reminded the Anesthesiologists and CRNAs to fill out all blanks in the consent form including signing, dating, and timing the form immediately after explaining the risks and benefits to the patient. The memo sent is attached as Exhibit 6. A memo was sent to Pre-Op Nurses on November 4, 2011 regarding the same. The memo sent is attached as Exhibit 7. The Quality Management Team will review 80% medical records to help ensure compliance Pinnacle's policies and procedures. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant physicians. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a quarterly basis. The Anesthesia Consent QA Form is attached as Exhibit 8. **Addendum- The Director of Nursing/Director of Surgical Services is charged with ensuring that the Hospital is in compliance with this standard.**	

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	at 11:40 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; iii. according to the Anesthesia Record, anesthesia administration started at 11:37 AM, which is prior to the physician explanation of risks and benefits statement. c. N4 Operative Report dated 7/1/11, indicated patient underwent IV sedation and lacked a properly executed informed consent form. d. N8 had a Consent for Operative or Diagnostic Procedures dated 4/6/11 and: i. physician authentication was timed at 11:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing Admission dated 4/6/11, Versed 2 mg and Fentanyl 100 mcg, both IVP (intravenous push), were administered at 10:46 AM, which is prior to the physician explanation of risks and benefits statement; iii. according to the Operative Record,			

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	anesthesia administration started at 10:47 AM, which is prior to the physician explanation of risks and benefits statement. e. N13 Operative Report dated 9/29/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures: i. was dated 9/30/11; ii. lacked a physician signature and time for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". f. N15 had a Consent for Operative or Diagnostic Procedures dated 3/22/11 and: i. physician authentication was timed at 9:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing Admission dated 3/22/11, Versed 2 mg and Fentanyl 100 mcg, both IVP (intravenous push), were administered at 8:56 AM, which is prior to the physician explanation of risks and benefits statement;			

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	iii. according to the Operative Record, anesthesia administration started at 9:00 AM, which is the same time of the physician explanation of risks and benefits statement. g. N16 had a Consent for Operative or Diagnostic Procedures dated 4/6/11 and: i. physician authentication was timed at 2:30 PM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Operative Record, anesthesia administration started at 2:21 PM, which is prior to the physician explanation of risks and benefits statement. h. N17 Operative Report dated 4/29/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures lacked a time of physician signature for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". i. N19 had a Consent for Operative or Diagnostic Procedures dated 8/31/11 and: i. physician authentication was timed			

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	at 6:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Operative Record, anesthesia administration started at 5:59 AM, which is prior to the physician explanation of risks and benefits statement. j. N20 had a Consent for Operative or Diagnostic Procedures dated 5/18/11 and: i. physician authentication was timed at 10:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing Admission dated 5/18/11, Versed 2 mg and Fentanyl 100 mcg, both IVP (intravenous push), were administered at 9:55 AM and 9:57 AM, respectively, which is the same time of the physician explanation of risks and benefits statement; iii. according to the Operative Record, anesthesia administration started at 10:00 AM, which is prior to the physician explanation of risks and benefits			

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	statement. k. N21 Operative Record dated 6/13/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures lacked a time of physician signature for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". 5. Personnel P14 was interviewed on 10/5/11 at approximately 9:10 AM, and confirmed the above-mentioned closed patient medical records lacked properly executed informed consent forms according to facility policy and procedure.			
A0630	Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. Based on review of medical record policies, patient records, and staff interview, the dietetic services failed to ensure nutritional needs were met in accordance with the orders of the practitioner or practitioners responsible for the patient's care for 2 of 4 patient records reviewed. Findings included:	A0630	On November 8, 2011 an educational session was provided by the Chief Operating Officer to Inpatient Staff at the Departmental Meeting about documentation of percentage of food intake. A memo was posted in the “Communication Book” in regards to food intake documentation. The policy and presentation from this education sessions is attached as Exhibit 9.	11/08/2011

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	1. Review of medical records policies on 10-5-11 between 12:05 PM and 12:15 PM revealed a policy titled: "Inpatient Medical Record Content", policy number "HIM-14", last revised "May 2009", which read: "Document accurately the course of treatment and results..." and "Clinical observations...documented in a timely manner..." and "The inpatient medical record shall document and contain...Nursing notes, nursing plan of care, medication records, and entries of other health care providers that contain pertinent, meaningful observations and information..." 2. Review of inpatient records on 10-5-11 between 11:30 AM and 11:55 AM revealed the following: a. Patient #L9 was admitted on 10-4-11. The physician ordered a "Cardiac diet" at "1450". The patient's record did not contain the observation of how much the patient ate during dinner to indicate the physician's orders were followed, as required by the above mentioned approved policy. b. Patient #L10 was admitted on 9-29-11. On "10-3-11", the dietician documented the following recommendations for the patient on the "Recommendation Form - Individual Resident Nutrition		The Quality Management Team will review 10 medical records a month to help ensure compliance Pinnacle's policies and procedures. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant staff. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a monthly basis. **Addendum- The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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	Recommendations/Response": "consider Boost Glucose Control with meals if pt. eats <= 75%...Needs ~2200 cals/day..." On "10-4-11" the patient's physician checked a box on the "Recommendation Form-Individual Resident Nutrition Recommendations/Response" form which read: "I agree with the recommendations". However, there was not a physician's order placed on the patient's chart for "Boost Glucose Control" or for a 2200 calorie diet. Nursing documentation from 10-1-11 to 10-4-11 indicated the patient received an "1800 ADA" diet and did not receive "Boost Glucose Control", even though the patient ate less than 75% of lunch and dinner on 10-2-11 and ate less than 75% of breakfast, lunch and dinner on 10-4-11. 3. In interview on 10-5-11 between 11:30 AM and 11:55 AM, Staff Member #L11 acknowledged the above findings.			
A0701	The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. Based on document review and staff interview, the facility failed to demonstrate assurance of patient safety by lack of preventive maintenance on 1 of 3 systems reviewed.	A0701	On November 10, 2011 a maintenance schedule log was developed by the Materials Management and Facility Operations Officer. The schedule log is used to ensure that all mechanical equipment is	11/10/2011

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	150166	A. BUILDING 00 B. WING	10/05/2011

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	Findings: 1. Upon document review October 5, 2011 at 1:30pm, no PM (preventive maintenance) information was made available for review for the nurse call (code) system. 2. Upon interview with Employee # A11 at 1:30pm, staff indicated no preventive maintenance is completed for the nurse call (code) system. 3. No further documentation was presented prior to survey exit.		maintained with the appropriate frequency and in accordance with the manufacturer's recommended schedule. In addition to this log there is a Call Light Testing Report log which is used to track nurse call (code) system checks. On a monthly basis the Materials Management and Facility Operations Officer will check the call system. The monthly checks will be reported to the Quality Management Team at their quarterly meeting. These logs are found under Exhibit 13. **Addendum- The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard.**	
A0703	There must be facilities for emergency gas and water supply. Based on document review and staff interview, the facility failed to show evidence of plan for emergency backup supply for fuel source. Findings: 1. Upon document review on October 5, 2011 at 1:30pm, no documentation was made available to review related to plan for emergency sources for fuel supply. 2. Upon interview with Employee #A11 on October 5, 2011 at 1:30pm, staff	A0703	Pinnacle does have a system in place to ensure that the hospital has access to fuel and water as needed to provide care to inpatients in need of the care. Pinnacle has made arrangements with Pinkerton Fuels and Lubricants to provide for emergency sources of fuel. On November 9, 2011,Pinnacle drafted Policy No. S29 Emergency Source of Fuel to indicate the system already in place. The policy notes that there must be facilities for emergency fuel and water supply. As noted in the policy on site fuel is available for the generator for 72	11/09/2011

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	indicated no plan for emergency fuel supply was available for review. 3. No further documentation was presented prior to time of survey exit.		hours. Additional fuel is available through Pinkerton Oil. The policy and agreement with Pinkerton is attached under Exhibit 10. **Addendum- An Emergency Generator Weekly Inspection Log checklist was created to track generator run times. This checklist is attached to this Plan of Correction. The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard and will report the results of weekly inspection logs to the Quality Management Team at their quarterly meeting.**	
A0837	The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure a transfer form was completed for 4 of 5 (N8, N9, N10 and N11) patients transferred to another acute care facility. Findings: 1. Policy titled, "Acute Care Transfer Form" reviewed on 10/5/11 at 10:54 AM, indicated on pg. 1, under: a. Purpose section, "The Acute Care Transfer Form will be completed for all transfers in order to provide the	A0837	Prior to the survey, Pinnacle's Quality Management Team identified challenges in the Transfer process and has already taken steps to address this issue. A training was provided to all staff on September 1, 2011 in regards to Pinnacle's transfer of patient process. At this training, staff were instructed on filling out the Transfer Log Form. Staff were also provided with a transfer packet that is used for each patient transfer. Staff were informed of how to fill out the forms and the appropriate forms to fill out for each transfer. The	11/01/2011

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	appropriate documentation required by federal law regarding any transfer out of [facility]." b. Procedure section, point 1.c., "A new form is initiated with each transfer." 2. Policy titled, "Chart, Patient's Record" reviewed on 10/5/11 at 11:07 AM, indicated on pg. 1, under Procedure section, point 1.0, "Every patient admitted to the hospital has a record which is a complete and accurate history of the hospital stay." 3. Review of closed patient medical records on 10/4/11 at 2:51 PM, indicated: a. N8 was transferred to another acute care facility on 4/6/11 and was lacking a completed Acute Care Transfer form. b. N9 was transferred to another acute care facility on 6/14/11 and was lacking a completed Acute Care Transfer form. There was a different Transfer Form completed, but lacked: the accepting physician name, date/time notified; risks and benefits; provider certification; and mode of transport. c. N10 was transferred to another acute care facility on 6/8/11 and was lacking a completed Acute Care Transfer form. d. N11 was transferred to another acute care facility on 9/22/11 and was lacking a completed Acute Care Transfer form.		training materials provided at the education session are attached under Exhibit 11. In September, a Transfer Monitor form was created to log QA activities. All transfers are documented in a logbook. Once transfers are documented the medical records corresponding to the transfers are reviewed for each transfer. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant staff. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a quarterly basis. **Addendum- The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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	4. Personnel P14 was interviewed on 10/5/11 at approximately 9:10 AM, and confirmed the above-mentioned closed patient medical records lacked a completed transfer form according to facility policy and procedure.			
S0390	410 IAC 15-1.4-1(f)(1) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (1) That a contractor of any service furnishes those services in such a manner as to permit the hospital to comply with all applicable statutes and rules. Based on document review and staff interview, the facility failed to demonstrate quality monitor indicators for 3 of 11 contracted services. Findings: 1. Document review of the hospital quality monitor indicators on October 5, 2011 at 1pm indicated three contracted services were not included in the monitor: Housekeeping; Rehab Services; and	S0390	On November 9, 2011, Pinnacle drafted Policy A-23 governing contractor services, including Physical Therapy Services and Mobile Services,provided in the hospital to ensure that as part of Pinnacle's QAPI program a Qualified Individual shall assess that services furnished by hospital staff and services provided under contract comply with all applicable state and federal rules and regulations. On November 18, 2011, the Governing Board of Pinnacle shall approve this policy. This policy is attached as Exhibit 1. Per the policy, the appropriate department manager is responsible for evaluating the service provided. A copy of the	11/09/2011

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	Mobile Services. 2. Interview with Employee #A2 and Employee #8 on October 5, 2011 at 1pm verified these findings.		report is forwarded to the Quality Assurance Department on a quarterly basis with the department's performance improvement report and the department manager will provide a report to the Utilization Review/Quality Assurance/Risk Management Committee along with the scheduled department performance improvement report. Specifically for Mobile Services, the QAPI monitor is designed to assure that the exam that is being scanned by the MRI technologist follows the Pinnacle Radiology department's expectation. The Quality Management Team will randomly select 5 exams per month to monitor all pertinent information with regards to the technological factors selected by the technologist to make sure it is consistent with Pinnacle's protocols. The Medical Director of Radiology will supervise the QI monitor along with the MRI Technologist. Attached as Exhibit 2 is the Mobile MRI QI Monitor Log. Attached as Exhibit 3 is the Physical Therapy and Occupational Therapy QI Monitor Log. Please note, that Housekeeping Services are not provided through contract, thus these services should not have been cited by the Surveyor. **Addendum-The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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S0536	410 IAC 15-1.5-1 (d)(1)(2)(3) (d) Menus shall meet the needs of the patients as follows: (1) Therapeutic diets shall be prescribed by the practitioner responsible for the care of the patient. (2) Nutritional needs shall be met in accordance with recognized dietary standards of practice and in accordance with the orders of the responsible practitioner. (3) A current therapeutic diet manual approved by the dietitian and medical staff shall be readily available to all medical, nursing, and food service personnel. Based on review of medical record policies, patient records, and staff interview, the dietetic services failed to ensure nutritional needs were met in accordance with the orders of the practitioner or practitioners responsible for the patient's care for 2 of 4 patient records reviewed. Findings included: 1. Review of medical records policies on 10-5-11 between 12:05 PM and 12:15 PM revealed a policy titled: "Inpatient Medical Record Content", policy number "HIM-14", last revised "May 2009", which read: "Document accurately the course of treatment and results..." and	S0536	On November 8, 2011 an educational session was provided by the Chief Operating Officer to Inpatient Staff at the Departmental Meeting about documentation of percentage of food intake. A memo was posted in the“Communication Book” in regards to food intake documentation. The policy and presentation from this education sessions is attached as Exhibit 9. The Quality Management Team will review 10 medical records a month to help ensure compliance Pinnacle’s policies and procedures. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant staff.	11/08/2011

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	"Clinical observations...documented in a timely manner..." and "The inpatient medical record shall document and contain...Nursing notes, nursing plan of care, medication records, and entries of other health care providers that contain pertinent, meaningful observations and information..." 2. Review of inpatient records on 10-5-11 between 11:30 AM and 11:55 AM revealed the following: a. Patient #L9 was admitted on 10-4-11. The physician ordered a "Cardiac diet" at "1450". The patient's record did not contain the observation of how much the patient ate during dinner to indicate the physician's orders were followed, as required by the above mentioned approved policy. b. Patient #L10 was admitted on 9-29-11. On "10-3-11", the dietician documented the following recommendations for the patient on the "Recommendation Form - Individual Resident Nutrition Recommendations/Response": "consider Boost Glucose Control with meals if pt. eats <= 75%...Needs ~2200 cals/day..." On "10-4-11" the patient's physician checked a box on the "Recommendation Form-Individual Resident Nutrition Recommendations/Response" form which read: "I agree with the		The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a monthly basis.**Addendum- The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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	recommendations". However, there was not a physician's order placed on the patient's chart for "Boost Glucose Control" or for a 2200 calorie diet. Nursing documentation from 10-1-11 to 10-4-11 indicated the patient received an "1800 ADA" diet and did not receive "Boost Glucose Control", even though the patient ate less than 75% of lunch and dinner on 10-2-11 and ate less than 75% of breakfast, lunch and dinner on 10-4-11. 3. In interview on 10-5-11 between 11:30 AM and 11:55 AM, Staff Member #L11 acknowledged the above findings.			
S0604	410 IAC 15-1.5-2(f)(3)(D)(vii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. Based on review of employee health policies and staff interview, the infection	S0604	On November 8, 2011 Pinnacle drafted a “Mandatory Reporting Required by Food Employees and	11/08/2011

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	control committee failed to establish a procedure in compliance with 410 IAC 4-24-120 to monitor the immune status of food service employees. Findings included: 1. 410 IAC 7-24-120 reads: "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), if the food employee or applicant: (1) is diagnosed with an illness due to: (A) Salmonella spp.; (B) Shigella spp.; (C) Shiga toxin-producing Escherichia coli; (D) hepatitis A virus; or (E) Norovirus; or (2) has a symptom caused by illness, infection, or other source that is:		Applicants" attached to its already existing "Staff Exposing Patients to Communicable Diseases" Policy. The attachment and policy are enclosed under Exhibit 12. This form complies with the requirements under 410 IAC 7-24-120. Each signed form will go into the employee's files. **Addendum- The Food Service Manager is charged with ensuring that the Hospital is in compliance with this standard.**	

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	(A) associated with an acute gastrointestinal illness, such as: (i) diarrhea; (ii) fever; (iii) vomiting; (iv) jaundice; or (v) sore throat with fever; or (B) a lesion containing pus, such as a boil or infected wound that is open or draining and is on: (i) the hands or wrists unless an impermeable cover, such as a finger cot or stall, protects the lesion and a single use glove is worn over the impermeable cover; (ii) exposed portions of the arms unless the lesion is protected by an impermeable cover; or (iii) other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; (3) had a past illness from an infectious agent specified under subdivision (1); or (4) meets one (1) or more of the following high-risk conditions, such as: (A) Being suspected of causing, or being exposed to, a confirmed disease outbreak caused by Salmonella spp., Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or norovirus because the food employee or applicant:			

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	(i) prepared food implicated in the outbreak; (ii) consumed food implicated in the outbreak; or (iii) consumed food at the event prepared by a person who is infected or ill with the infectious agent that caused the outbreak or who is suspected of being a shedder of the infectious agent. (B) Living in the same household as a person who is diagnosed with a disease caused by Salmonella spp., Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or norovirus. 2. Review of employee health policies on 10-5-11 between 11:55 AM and 12:05 PM revealed a policy titled: "Employee Health", policy number unknown, effective date "June 2007", which did not include the requirements in 410 IAC 7-24-120 for food service employees. 3. In interview on 10-5-11 between 11:55 AM and 12:05 PM, Staff Member #10 acknowledged the above findings and conveyed the hospital did not have a policy for food service workers that was in compliance with 410 IAC 7-24-120.			

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S0788	410 IAC 15-1.5-4(i)(9) (i) Emergency service records shall document and contain, but not be limited to, the following: (9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded. Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure a transfer form was completed for 4 of 5 (N8, N9, N10 and N11) patients transferred to another acute care facility. Findings: 1. Policy titled, "Acute Care Transfer Form" reviewed on 10/5/11 at 10:54 AM, indicated on pg. 1, under: a. Purpose section, "The Acute Care Transfer Form will be completed for all transfers in order to provide the appropriate documentation required by federal law regarding any transfer out of [facility]." b. Procedure section, point 1.c., "A new form is initiated with each transfer." 2. Policy titled, "Chart, Patient's Record" reviewed on 10/5/11 at 11:07 AM, indicated on pg. 1, under Procedure	S0788	Prior to the survey, Pinnacle's Quality Management Team identified challenges in the Transfer process and has already taken steps to address this issue. A training was provided to all staff on September 1, 2011 in regards to Pinnacle's transfer of patient process. At this training, staff were instructed on filling out the Transfer Log Form. Staff were also provided with a transfer packet that is used for each patient transfer. Staff were informed of how to fill out the forms and the appropriate forms to fill out for each transfer. The training materials provided at the education session are attached under Exhibit 11. In September, a Transfer Monitor form was created to log QA activities. All transfers are documented in a logbook. Once transfers are documented the medical records corresponding to the transfers are reviewed for each transfer. If the Quality Management Team finds compliance is less than 95%, the	11/01/2011

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	section, point 1.0, "Every patient admitted to the hospital has a record which is a complete and accurate history of the hospital stay." 3. Review of closed patient medical records on 10/4/11 at 2:51 PM, indicated: a. N8 was transferred to another acute care facility on 4/6/11 and was lacking a completed Acute Care Transfer form. b. N9 was transferred to another acute care facility on 6/14/11 and was lacking a completed Acute Care Transfer form. There was a different Transfer Form completed, but lacked: the accepting physician name, date/time notified; risks and benefits; provider certification; and mode of transport. c. N10 was transferred to another acute care facility on 6/8/11 and was lacking a completed Acute Care Transfer form. d. N11 was transferred to another acute care facility on 9/22/11 and was lacking a completed Acute Care Transfer form. 4. Personnel P14 was interviewed on 10/5/11 at approximately 9:10 AM, and confirmed the above-mentioned closed patient medical records lacked a completed transfer form according to facility policy and procedure.		Quality Management Team will implement additional education and training programs with respect to non-compliant staff. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a quarterly basis. **Addendum- The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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S0952	410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on review of policies and procedures, patient records, and staff interview, nursing services failed to ensure blood transfusions were administered in accordance with approved policies and procedures for 6 of 8 patient records reviewed. Findings included: 1. Review of policies and procedures on 10-5-11 between 11:10 AM and 11:30 AM revealed a policy/procedure titled: Blood, Blood Products, Derivatives Administration", policy number: "PCS B-8", last revised "10/09", which read: "Packed cells/blood..never exceed 4 hours from the time the bag is taken out of the validated cooler..." and "Blood transfusion must must initiated within thirty minutes from the time the bag is removed from the validated cooler..." and "Assess vitals (T,P, and B/P) within 1 hour prior to administration and sign	S0952	On November 9, 2011 the Blood Cooler Log was revised to ensure that blood transfusions are administered in accordance with Pinnacle's policies and procedures. The Nurse is required to record the time blood units are removed from the cooler. Nurses were educated about this new log on November 9, 2011. The revised log and meeting minutes from the education session is attached as Exhibit 4. On November 18, 2011, the Governing Board of Pinnacle shall approve this revised log. The Quality Management Team will review every blood cooler log to help ensure compliance Pinnacle's policies and procedures. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant staff. The Quality Management Team will review all audit reports and present all audit reports to the	11/09/2011

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	150166	A. BUILDING 00 B. WING	10/05/2011

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	record." and "Reassess vitals (T,P, B/P)...fifteen minutes after "start time" (plus or minus 5 minutes is acceptable)..." 2. Review of patient records on 10-5-11 between 12:15 PM and 2:35 PM revealed the following: a. Patient #L1 was admitted on 7-6-11 and discharged on 7-8-11. The patient received 2 units of leukoreduced packed red blood cells (LR PRBC). The first transfusion was initiated on 7-7-11 at "1130 AM" and the second transfusion was initiated at "1325" on the same date. The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes from the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. b. Patient #L2 was admitted on 9-12-11 and discharged on 9-13-11. The patient received 2 units of LR PRBC's. The first transfusion was initiated on 9-13-11 at "0140" and fifteen minute vital signs were taken at "0140", the same time the transfusion was initiated. The second transfusion was started at "0520" on the same date. The time each unit was removed from the validated cooler was not documented, therefore the surveyor		Board of Managers on a quarterly basis. **Addendum-The Chief Operating Officer is charged with ensuring that the Hospital is in compliance with this standard.**	

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	was unable to determine if the transfusions were initiated with 30 minutes from the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. c. Patient #L4 was admitted on 6-8-11 and discharged on 6-8-11. The patient received 2 units of LR PRBC's on 6-8-11. The first transfusion was initiated at "1359" and the second transfusion was initiated at "1406". The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. d. Patient #L5 was admitted on 5-13-11 and discharged on 5-16-11. The patient received 2 units of LR PRBC's. The first transfusion was initiated on 5-14-11 at "1045" and the second transfusion was initiated on 5-15-11 at "0045". The time each unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusions were initiated with 30 minutes for the time the blood was removed from the			

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	cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. e. Patient #L7 was admitted on 3-29-11 and discharged on 4-7-11. The patient received one unit of LR PRBC's on 3-30-11, which was initiated at "1712". The time the unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusion was initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. f. Patient #L8 was admitted on 9-22-11 and discharged on 9-26-11. The patient received one unit of LR PRBC's on 9-25-11, which was initiated at "1738." The time the unit was removed from the validated cooler was not documented, therefore the surveyor was unable to determine if the transfusion was initiated with 30 minutes for the time the blood was removed from the cooler and if the blood was out of the validated cooler no more than 4 hours, as required by approved policies and procedures. 3. In interview on 10-5-11 between 1:20 PM and 2:35 PM, Staff Member #L11 acknowledged the above findings and			

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	conveyed the facility did not document the time units of blood were removed from the validated coolers.			
S1122	410 IAC 15-1.5-8 (b)(4) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (4) There shall be a plan for emergency fuel and water supply. Based on document review and staff interview, the facility failed to show evidence of plan for emergency backup supply for fuel source. Findings: 1. Upon document review on October 5, 2011 at 1:30pm, no documentation was made available to review related to plan for emergency sources for fuel supply. 2. Upon interview with Employee #A11 on October 5, 2011 at 1:30pm, staff indicated no plan for emergency fuel supply was available for review. 3. No further documentation was presented prior to time of survey exit.	S1122	Pinnacle does have a system in place to ensure that the hospital has access to fuel and water as needed to provide care to inpatients in need of the care. Pinnacle has made arrangements with Pinkerton Fuels and Lubricants to provide for emergency sources of fuel. On November 9, 2011,Pinnacle drafted Policy No. S29 Emergency Source of Fuel to indicate the system already in place. The policy notes that there must be facilities for emergency fuel and water supply. As noted in the policy onsite fuel is available for the generator for 72 hours. Additional fuel is available through Pinkerton Oil. The policy and agreement with Pinkerton is attached under Exhibit 10. **Addendum- An Emergency Generator Weekly Inspection Log checklist was created to track generator run times. This**	11/09/2011

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			checklist is attached to this Plan of Correction. The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard and will report the results of weekly inspection logs to the Quality Management Team at their quarterly meeting.	
S1162	410 IAC 15-1.5-8(d)(2)(A) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on document review and staff interview, the facility failed to demonstrate assurance of patient safety by lack of preventive maintenance on 1 of 3 systems reviewed. Findings: 1. Upon document review October 5, 2011 at 1:30pm, no PM (preventive maintenance) information was made	S1162	On November 10, 2011 a maintenance schedule log was developed by the Materials Management and Facility Operations Officer. The schedule log is used to ensure that all mechanical equipment is maintained with the appropriate frequency and in accordance with the manufacturer's recommended schedule. In addition to this log there is a Call Light Testing Report log which is used to track nurse call (code) system checks.	11/10/2011

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	available for review for the nurse call (code) system. 2. Upon interview with Employee # A11 at 1:30pm, staff indicated no preventive maintenance is completed for the nurse call (code) system. 3. No further documentation was presented prior to survey exit.		On a monthly basis the Materials Management and Facility Operations Officer will check the call system. The monthly checks will be reported to theQuality Management Team at their quarterly meeting. These logs are found under Exhibit 13. **Addendum- The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard.**	
S2122	410 IAC 15-1.6-8 (c)(3) (c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows: (3) A properly executed informed consent form for the operation shall be in the patient's chart before surgery, except in extreme emergencies. Based on document review, policy and procedure review, medical record review, and staff interview, the facility failed to ensure a properly executed informed consent form was in the patient's chart as required per facility policy and procedure for 11 of 22 (N2, N3, N4, N8, N13, N15-N17, and N19-N21) closed patient medical records reviewed. Findings:	S2122	A memo was sent on November 4, 2011 to all Pinnacle Surgeons educating the surgeons about the policies and Hospital bylaw provisions in regard to physician signatures,dates and times of authentications. The materials provided informed surgeons of the need for signature and time to be documented on the Consent for Operative or Diagnostic Procedures. The memo sent is attached as Exhibit 5. Signs are being posted in the PACU area,	11/04/2011

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	1. Review of Medical Staff Rules and Regulations on 10/5/11 at 11:00 AM, indicated on pg. 12, point 18., "All clinical entries shall be dated, timed and authenticated..." 2. Policy titled, "Consent to Operation and Anesthesia Services" reviewed on 10/5/11 at 10:34 AM, indicated on pg. 1, under Procedure section, points 1.D. & E., "All blanks on the consent form must be filled in. If the item is not-applicable, place N/A in the blank and/or draw lines to fill in the blank...The patient must sign the consent before he receives a sedative or mind-altering medication..." 3. Policy titled, "Surgical Consent" reviewed on 10/5/11 at 10:39 AM, indicated on pg. 1, under Procedure section, point 4., "Each patient will be provided with informed consent." 4. Review of closed patient medical records on 10/4/11 at 2:51 PM, indicated: a. N2 had a Consent for Operative or Diagnostic Procedures dated 4/20/11, but was lacking physician signature and time for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if		the physician's lounge, and the inpatient unit reminding surgeon's of this requirement. Further, a memo was sent on November 4, 2011 to all Pinnacle Anesthesiologists and CRNAs in regards to Pinnacle's policies on Anesthesia consent. The memo reminded the Anesthesiologists and CRNAs to fill out all blanks in the consent form including signing, dating, and timing the form immediately after explaining the risks and benefits to the patient. The memo sent is attached as Exhibit 6. A memo was sent to Pre-Op Nurses on November 4, 2011 regarding the same. The memo sent is attached as Exhibit 7. The Quality Management Team will review 80% medical records to help ensure compliance Pinnacle's policies and procedures. If the Quality Management Team finds compliance is less than 95%, the Quality Management Team will implement additional education and training programs with respect to non-compliant physicians. The Quality Management Team will review all audit reports and present all audit reports to the Board of Managers on a quarterly basis. The Anesthesia Consent QA Form is attached as Exhibit 8. **Addendum- The Director of Nursing/Director of Surgical Services is charged with ensuring that the Hospital is in**	

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	applicable." b. N3 had a Consent for Operative or Diagnostic Procedures dated 8/4/11 and: i. time of patient's authentication was lacking; ii. physician authentication was timed at 11:40 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; iii. according to the Anesthesia Record, anesthesia administration started at 11:37 AM, which is prior to the physician explanation of risks and benefits statement. c. N4 Operative Report dated 7/1/11, indicated patient underwent IV sedation and lacked a properly executed informed consent form. d. N8 had a Consent for Operative or Diagnostic Procedures dated 4/6/11 and: i. physician authentication was timed at 11:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing Admission dated 4/6/11, Versed 2 mg and		**compliance with this standard.**	

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	Fentanyl 100 mcg, both IVP (intravenous push), were administered at 10:46 AM, which is prior to the physician explanation of risks and benefits statement; iii. according to the Operative Record, anesthesia administration started at 10:47 AM, which is prior to the physician explanation of risks and benefits statement. e. N13 Operative Report dated 9/29/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures: i. was dated 9/30/11; ii. lacked a physician signature and time for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". f. N15 had a Consent for Operative or Diagnostic Procedures dated 3/22/11 and: i. physician authentication was timed at 9:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing			

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	Admission dated 3/22/11, Versed 2 mg and Fentanyl 100 mcg, both IVP (intravenous push), were administered at 8:56 AM, which is prior to the physician explanation of risks and benefits statement; iii. according to the Operative Record, anesthesia administration started at 9:00 AM, which is the same time of the physician explanation of risks and benefits statement. g. N16 had a Consent for Operative or Diagnostic Procedures dated 4/6/11 and: i. physician authentication was timed at 2:30 PM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Operative Record, anesthesia administration started at 2:21 PM, which is prior to the physician explanation of risks and benefits statement. h. N17 Operative Report dated 4/29/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures lacked a time of physician signature for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or			

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	procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". i. N19 had a Consent for Operative or Diagnostic Procedures dated 8/31/11 and: i. physician authentication was timed at 6:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Operative Record, anesthesia administration started at 5:59 AM, which is prior to the physician explanation of risks and benefits statement. j. N20 had a Consent for Operative or Diagnostic Procedures dated 5/18/11 and: i. physician authentication was timed at 10:00 AM for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable"; ii. according to the Pre-Op Nursing Admission dated 5/18/11, Versed 2 mg and Fentanyl 100 mcg, both IVP (intravenous push), were administered at 9:55 AM and 9:57 AM, respectively, which is the same time of the physician			

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	explanation of risks and benefits statement; iii. according to the Operative Record, anesthesia administration started at 10:00 AM, which is prior to the physician explanation of risks and benefits statement. k. N21 Operative Record dated 6/13/11, indicated patient underwent General anesthesia and Consent for Operative or Diagnostic Procedures lacked a time of physician signature for the statement: "I have explained the specific indications, alternatives, risks, benefits and complications of the operation or procedure, as well as the possible need for alternatives, risks and benefits of transfusion therapy, if applicable". 5. Personnel P14 was interviewed on 10/5/11 at approximately 9:10 AM, and confirmed the above-mentioned closed patient medical records lacked properly executed informed consent forms according to facility policy and procedure.			