

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153030	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2012
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NAME OF PROVIDER OR SUPPLIER REHABILITATION HOSPITAL OF FORT WAYNE GENERAL PAR	STREET ADDRESS, CITY, STATE, ZIP CODE 7970 W JEFFERSON BLVD FORT WAYNE, IN 46804
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/20/1012 through 8/22/2012</p> <p>Facility Number: 006245</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 08/23/12</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review, the facility failed to ensure 1 service (blood receipt) provided by a contractor as part of it's comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 2012 Performance Improvement Plan, approved 5/2/2012, implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Review of the facility's 2012 	S0406	The facility has been tracking that each unit of blood received from the contracted blood bank is received within the appropriate temperature range and that it passes a visual inspection. This information has been reported to the Chief Nursing Officer/Quality Coordinator monthly, but it was not being reported up through the Performance Improvement (PI) Committee. The data for 2012 to date will be prepared by September 21, 2012 and will then be presented by the Chief Nursing Officer/Quality Coordinator at our next PI Committee on September 26, 2012. Future data will be collected monthly and will be presented at least quarterly in PI Committee following this date by the Chief Nursing Officer/Quality Coordinator. This new reporting practice will be	09/21/2012	

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	<p>Performance Improvement program indicated it lacked the contracted service of the receiving of blood from #F2.</p> <p>3. At 1:00 PM on 8/21/2012, staff member #11 indicated Rehabilitation Hospital of Fort Wayne receives blood from #F2. The staff member indicated the hospital has not monitored the receiving of blood from #F2.</p>		ongoing.Addendum: The person responsible for implementing this POC is the Chief Nursing Officer.		

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S0536	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1 (d)(1)(2)(3)</p> <p>(d) Menus shall meet the needs of the patients as follows:</p> <p>(1) Therapeutic diets shall be prescribed by the practitioner responsible for the care of the patient.</p> <p>(2) Nutritional needs shall be met in accordance with recognized dietary standards of practice and in accordance with the orders of the responsible practitioner.</p> <p>(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.</p> <p>Based on policy review, medical record review, and interview, the Dietary Services failed to ensure the nutritional needs of the patient were prescribed by the practitioner caring for the patient in 3 of 4 patient records reviewed (#N13, N14, and N15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of policy documentation regarding the dietary services failed to indicate the process for the dietician's recommendations to be relayed to the physician for orders as needed or desired. The medical record for patient #N13, 	S0536	The policy for documentation by the Registered Dietician (RD) is being revised to reflect that the RD has a form that she will utilize to make recommendations to the licensed independent practitioner (LIP) from her initial admission assessment and subsequent assessments. The form will be placed under the physician orders tab in the patient chart for the LIP to review, sign, date and time if they choose to make the recommendation an official order. The form will also include an area for the LIP to mark if they choose not to make the recommendations an order and the LIP will sign, date and time this declination. The policy revisions and the new form	09/19/2012			

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	<p>admitted 03/12/12 and discharged 03/27/12, indicated a dietician's evaluation on 03/13/12 with recommendations of "daily MVI [multivitamin], increased PRO pudding and/or shake at each meal to supplement po [oral] intake". The medical record lacked any documentation of these recommendations being relayed to the physician or any orders that they were implemented. There was also no further documentation by the dietician regarding these recommendations.</p> <p>3. The medical record for patient #N14, admitted 04/20/12 and discharged 05/02/12, indicated a dietician's evaluation on 04/23/12 with recommendations of "Encourage adequate fluids daily, monitor po [oral] intake, check Vitamin D level". The medical record lacked any documentation of these recommendations being relayed to the physician or any orders that they were implemented. The dietician saw the patient again on 04/27/12, but there was no further documentation regarding these recommendations.</p> <p>4. The medical record for patient #N15, admitted 05/16/12 and discharged 05/25/12, indicated a dietician's evaluation on 05/17/12 with recommendations of "1. daily MVI, 2.</p>		<p>development and implementation will be completed by the Chief Nursing Officer/Quality Coordinator, the Dietary Manager, and the RD by September 19, 2012. Monitoring of compliance of the new process will be completed by the Chief Nursing Officer/Quality Coordinator and the Dietary Manager by completing 10 random chart audits per month noting completeness of followthrough of RD recommendations. Any fall-outs will be reviewed with the RD at the time they are noted. Audits will continue until we are 100% complaint for at least 3 consecutive months. Addendum: If the recommendations from the RD are declined, the attending physician or their representative will be responsible for writing an order for an alternative option to meet the nutritional needs of the patient. The person responsible for this POC is the Chief Nursing Officer.</p>		

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	<p>adequate fluids, but not to exceed 1200 ml. FR (milliliters, fluid restrictions), 3. check prealbumin level". The medical record indicated the multivitamin and the fluid restrictions were part of the admission orders from 05/16/12. There was no documentation that the dietician's recommendations were relayed to the physician or that the prealbumin level was done. On 05/21/12, the dietician indicated on the Progress Notes, "...Rec. checking Vit. D level and prealbumin." Again, there was no documentation of this being communicated to the physician.</p> <p>5. At 10:30 AM on 08/22/12, the dietician supervisor, staff member #A16, indicated the dietician can talk to the physician or the patient's nurse or write the recommendations on a blue communication sheet. He/she confirmed the policy does not actually specify how the dietician's recommendations are to be communicated to the patient's practitioner to result in orders.</p> <p>6. At 11:30 AM on 08/22/12, staff member #A2 indicated the facility was cited previously because the dietician wrote their recommendations on the physician orders and that process had to be changed. The change specified the dietitian should communicate dietary needs to the physician or allied health</p>			

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	provider via face-to-face, telephone, or written communication. The dietician was contracted from Lutheran Hospital and their policy didn't really address the process in this facility. Staff member #A2 confirmed the apparent breakdown in the communication system.			

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S0748	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based on policy and procedure review, medical record review, and interview, the facility failed to ensure all entries in the medical records were authenticated and dated according to policy in 5 of 15 records reviewed (#N1, N2, N4, N6, and N14).</p> <p>Findings included:</p> <p>1. The facility policy "Documentation Requirements of the Medical Record", last reviewed 06/12, indicated, "...10. The medical record must contain final diagnoses with completion of medical records within 30 days following discharge. ...F. Plan of Care: The physician initiates the plan of care in the pre-assessment screen and H&P [history and physical] upon admission. The interdisciplinary team provides input into the plan of care and the physician signs off completion by day 4. ...I. Discharge Summary: The discharge summary should be concise, contain only essential information regarding the patient's illness and treatment, and should be written or</p>	S0748	<p>Signature on Plan of Care by day 4: This will be corrected by placing Plan of Care Concurrence form within the physicians' orders section of the chart for ease of access. HIM Manager/ PPS Coordinator will request Information Services to print the Plan of Care Concurrence Form within the Physician Order Section of the Chart for all admissions. Staff will be educated via a e-Memo and their respective leader that as of Sept 18 this will be the form location and that it should not be removed from the chart. The appointed Administrative team members (PPS Coordinator, COO, Director of Therapy/CM, Director of Admissions) of the Rehab Hospital will continue to complete monthly random Medicare/Medicare Advantage Chart audits (10 per month total) to ensure compliance. Individual education will be provided to those physicians that do not meet the requirement on a case by case basis. Authentication of Records within 30 days of Discharge: The deficiency related</p>	09/21/2012			

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	<p>dictated promptly after the patient's discharge and no later than 30 days following discharge."</p> <p>2. The facility policy "Verbal/Telephone Orders", last reviewed 07/11, indicated, "...Verbal/telephone orders shall include date and time order is written. All verbal/telephone orders will use the repeat and verify process. ...Verbal/telephone orders shall be tagged by nursing personnel to alert the physician that he/she has orders to sign. The physician shall authenticate read-back and verify orders no later than 30 days after the patient's discharge..."</p> <p>3. The medical record for patient #N1 indicated a discharge date of 07/07/12, a discharge summary dictated 08/02/12, but not signed by the physician until 08/09/12, over 30 days from discharge.</p> <p>4. The medical record for patient #N2, admitted 07/01/12 and discharged 07/10/12, indicated the Plan of Care was not authenticated as approved by the physician until 08/02/12, over 3 weeks after discharge.</p> <p>5. The medical record for patient #N4, admitted 03/24/12 and discharged 04/10/12, indicated the Plan of Care was not authenticated as approved by the</p>		<p>to authentications not being signed within the 30 day time frame will be corrected by re-educating the admitting and attending physicians of the requirement to authenticate entries in the Medical record within stated 30-day time frame. A Memorandum will be sent and posted in the physician dictation areas to remind physicians of the requirement and the importance of checking the Rehab Hospital Physician portal at least once a week (see attached Memorandum/posting exhibit A)The HIM Manager/ PPS Coordinator, COO, and new Medical Director will follow policy that provides notice of delinquencies at specified intervals (see attached policy "Notification of Physicians of Incomplete or Delinquent Records")Addendum: The person responsible for implementing this POC is Chief Operating Officer.</p>				

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	<p>physician until 04/02/12, 9 days later.</p> <p>6. The medical record for patient #N6, admitted 05/12/12 and discharged 05/18/12, indicated the Plan of Care was not authenticated as approved by the physician until 05/17/12, 5 days later.</p> <p>7. The medical record for patient #N14, admitted 04/20/12 and discharged 05/02/12, indicated telephone orders from the physician on 04/27/12 that were not authenticated by the physician until 06/13/12.</p> <p>8. At 11:30 AM on 08/22/12, staff members #A2 and A11 confirmed the medical record findings and indicated the records were not completed according to policy.</p>				

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S0936	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities. Based on policy review, employee file review, and interview, the facility failed to ensure competency of 1 of 1 Patient Safety Technicians (#A14).</p> <p>Findings included:</p> <p>1. The facility policy "Establishing and Insuring Competency", last reviewed 11/11, "...1. Associates will complete Initial Competency and Specific Annual Competency Checklists. ...Procedures on the list must be checked off before the associate is allowed to perform them without supervision. ...3. A designated staff member or members will validate each procedure/skill on the Annual Competency Checklist. ...New Associates: 1. All new Associates will be assigned to a more experienced, clinically competent peer or supervisor, who will act as a resource for questions and problem solving. This mentor, in conjunction with the immediate supervisor, will be responsible for evaluation of the new associate's</p>	S0936	<p>During the survey, a total of 15 files were pulled for review from the Nursing Services Team. The PST file was the only file with issues, all other files were without findings. As was explained to the surveyor, it is believed that the associate misplaced her original document that had been completed with her Mentor/Preceptor through her orientation. In an effort to complete the documentation within the 90 day time frame to complete her HR file, the Nurse Manager reviewed each item on the initial competency sheet again with the PST and had the PST verbalize her understanding in each area. Since the whole repeat competency was completed with the Nurse Manager, she was the only one that then signed the document. Other testing and competencies are noted within the associates file dated 02-04-09 with her start date being 01-28-09. The test that the PST did not complete correctly the first time on 02-04-09 has a note at the bottom from the Nurse</p>	09/10/2012

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	<p>competency in the areas in which they have been assigned. 2. Competencies will be documented on the Initial Competency checklist, and completed within the first 90 days of employment, if the associate is to perform these without supervision."</p> <p>2. The employee file for staff member #A14, a Patient Safety Technician, hired 01/28/09, was reviewed. The Initial Competency form listed the various skills, tasks, and knowledge expected from the employee and was divided into 3 sections, "Pre-Orientation Knowledge Level, Skill Verbalized, Skill Demonstrated". The "Pre-Orientation Knowledge" was scored 1, 2, or 3 and out of 19 tasks/skills, eight were marked with a 2 and two were marked with a 1, indicating a lack of knowledge in those areas. All of the tasks/skills were initialed and dated 04/23/09 in the "Skill Verbalized", but the section "Skill Demonstrated" was not signed or dated in any of the areas. The last page of the form contained the employee's signature and a manager's signature (the same person who initialed the tasks/skills area) from 04/23/09, but lacked any signatures of preceptors.</p> <p>The employee file also contained a "Safety Test for Patient Safety Tech" on which the employee missed 3 of the 5</p>		<p>Manager that the above wrong answers were discussed with the associate and the associate was able to state her understanding of the correct answers. In an effort to assure that this does not happen again, no competency paperwork will be allowed to leave the facility, thus minimizing the risk of documentation being lost. Each PST competency sheet will be reviewed and signed off by the Mentor/Preceptor, the Nurse Manager (if different from the Mentor/Preceptor) and the Chief Nursing Officer within the 90 day time frame. As each task is verbalized and/or demonstrated, it will be marked appropriately on the competency form. Audits by the Chief Nursing Officer will be completed and will continue on PST files until we have demonstrated that there are no issues over a 6 month period of time or until we determine that we will no longer be hiring additional PSTs. At this time, the later is the most likely. Addendum: The person responsible for completing this POC is the Chief Nursing Officer.</p>				

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	<p>questions. A notation was written on the test that the wrong answers were discussed with the employee, but lacked a signature or date. Also, the test was dated 02/04/08 which was before the employee was hired.</p> <p>3. At 11:00 AM on 08/22/12, staff member #A2 indicated the employee's competency checklist should have been completed and signed. He/she indicated this position was trained on-the-job by a preceptor and indicated staff member #A14's form was signed by a manager who would not have been the trainer/preceptor. He/she could not explain the date on the Safety Test.</p>				

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(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 policy review, medical record review, and interview, the facility failed to ensure blood transfusions were administered according to facility policy for 5 of 5 patients who received blood transfusions (#N1, N2, N4, N5, and N6).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Obtaining Blood and Blood Products from Lutheran Hospital Blood Bank", last reviewed 10/09, indicated, "...Blood must be checked in and hung within 30 minutes of arrival. ...Keypoint: All blood must be fully transfused within four hours after removal from styrofoam container." The facility policy "Transfusion of Blood or Blood Products", last reviewed 05/11, indicated, "...I. Sign, date, and time the form with the other nurse. J. Assess the patient, including temperature, 	S0952	An educational poster presentation was provided to Nursing within the first two weeks of July 2012 related to how the blood transfusion documentation is to be completed for each transfusion. At the time that this documentation was presented, it was not required for review. This education will now be required to be completed by all nurses by September 21, 2012. The Interim Quality Analyst and the Chief Nursing Officer/Quality Coordinator will continue to audit 100% of blood transfusions. Audits will be reviewed each month and 1:1 education will be provided with any nurse that has a documentation error or omission within the blood transfusion record. The data from January 1, 2012- August 31, 2012 monthly audits will be reported up through the Performance Improvement Committee Meeting on September 26, 2012 by the Chief	09/21/2012			

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	<p>pulse, respirations, and blood pressure. Elevated temperature of greater than 100 degrees should be reported to the physician prior to beginning the transfusion to assure no change in transfusion orders. ...R. Vital Signs Monitoring & Documentation: 1. Immediately prior to initiating transfusion. 2. Immediately following initiation (when blood meets IV [intravenous] site) of the transfusion. 3. Fifteen minutes after initiation (when blood meets IV site) of the transfusion. 4. Every one hour during transfusion or more frequently if patient's condition warrants. ...Keypoint: Blood or blood products must not be at room temperature longer than four hours due to increased potential for bacterial growth."</p> <p>3. The Blood Transfusion Form from 07/03/12 for patient #N1 lacked documentation of a time the unit was removed from remote storage and whether or not there was a transfusion reaction.</p> <p>4. The Blood Transfusion Form from 07/02/12 for patient #N2 indicated the unit was removed from the remote storage at 2110, but not started until 2127. The one hour vital signs were documented at 2215 which was one hour from the pre-transfusion vital signs, not the start</p>		<p>Nursing Officer/Quality Coordinator. Data will be collected and reviewed by the Interum Quality Analyst or designee and the Chief Nursing Officer/Quality Coordinator on a monthly basis and will be reported up through the Performance Improvement Committee at least once per quarter. This process will be ongoing. Addendum: The person responsible for completing this POC is the Chief Nursing Officer.</p>	

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	<p>time. The patient's pre-transfusion temperature was 100.5 degrees and the medical record lacked any documentation of physician notification prior to beginning the transfusion.</p> <p>5. The Blood Transfusion Form from 03/27/12 for patient #N4 lacked documentation of a date or time the unit was removed from remote storage.</p> <p>6. A Blood Transfusion Form from 04/28/12 for patient #N5 lacked documentation of a signature, date or time the unit was removed from remote storage and whether or not there was a transfusion reaction. A second form from the same day also lacked documentation of a signature, date or time the unit was removed from remote storage.</p> <p>7. The Blood Transfusion Form from 05/14/12 for patient #N6 indicated the unit was removed from remote storage at 1535, but not started until 1600. Three times and six vital signs were written over/changed and not corrected according to policy. A second form from the same day indicated the unit was removed from remote storage at 1840, started at 1915, and completed at 2315, over 4 and one half hours later. One time and one vital sign were written</p>				

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	<p>over/changed on the form.</p> <p>8. At 3:30 PM on 08/21/12, staff members #A2 and A11 confirmed the medical record findings and indicated the forms were not completed according to policy and acceptable standards of practice.</p>				

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(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:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in one (1) instance, outside generator.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Plant Operation policy PO-1001 last reviewed 1/10 notes the Rehabilitation Hospital of Fort Wayne will comply with NFPA codes, OSHA regulations, and Department of Health regulations. Because 1910.178 does not have 	S1118	Maintenance Free Batteries were ordered and installed 9/07/2012 thereby eliminating the requirement for installation of an eye-wash station. Director of Facilities was responsible for completion of the battery replacement. Maintenance-Free batteries will remain with monthly testing to be completed according to policy.	09/07/2012

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	<p>a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 1:05 PM on 8/20/2012, the outside enclosed generator was inspected. The generator was behind a stone wall approximately 50 yards away from the hospital. The diesel generator was observed inside a steel building. The generator was observed with 2-12</p>			

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	<p>volt batteries. The batteries are not maintenance free and the generator building does not have an eye-washing station that meets to 15 minute flushing of eyes.</p> <p>4. At 3:00 PM on 8/21/2012, staff member #10 indicated the facility conducts weekly inspections on the generator which includes checking the water level of the batteries.</p>			
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S1160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on documentation review, the facility failed to ensure the MAC 5000 resting ECG analysis system had its preventive maintenance according to the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The Mac 5000 resting ECG analysis system field service manual states, "Regular maintenance is essential to ensure that the equipment will always be functional when required. To help you establish a systematic maintenance routine, we recommend that every six months, you perform the maintenance checks and test procedures on the 'Preventive Maintenance Inspection Report' at the end of this chapter."</p>	S1160	<p>Field Service Manual for the MAC 5000 resting ECG analysis system PN 2000657-074 Revision B was reviewed. Biomedical Engineering Department Director has changed the preventative maintenance (PM) intervals for this machine from annual to semi-annual effective 9/07/12. The last PM was performed 6/12/12. Next PM due date is now 12/12/12 to be performed by Biomedical Engineering Department. Addendum: Scheduled PMs will be monitored and reported through Safety Committee meetings. The person responsible for completing this POC is the Chief Operating Officer.</p>	09/07/2012	

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	<p>The manual notes a Warning. The Warning states, "Failure on the part of all responsible individuals, hospitals or institutions, employing the use of this device, to implement the recommended maintenance schedule may cause equipment failure and possible health hazards."</p> <p>2. Lutheran Hospital Bioengineering Department conducts the preventive maintenance on the medical equipment at Rehabilitation Hospital of Fort Wayne. The electrocardiograph is scheduled to have an annual preventive maintenance. The last two Preventive Maintenance on the piece of equipment were 6/12/12 and 6/7/2011.</p> <p>3. At 2:00 PM on 8/21/2012, Staff member #9 indicated the recommendation for preventive maintenance in the service manual was only a recommendation and not a requirement. The staff member</p>			

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	confirms the ECG was on an annual preventive maintenance schedule.			