

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151330	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2014
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NAME OF PROVIDER OR SUPPLIER ADAMS MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 MERCER AVE DECATUR, IN 46733
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/26/2014 through 8/28/2014</p> <p>Facility Number: 004747</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 09/19/14</p>	S000000		
S000406	<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</p>			

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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	<p>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 and staff interview, the facility failed to ensure Electroencephalography (EEG), Pediatrics, Transcription, Electromyography (EMG) and internal Laundry services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Adams Memorial Hospital 2014 Quality Improvement Plan implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Quality improvement department dashboards were reviewed and there was no documented evidence that EEG, Pediatrics, Transcription, EMG and internal Laundry services were part 	S000406	<p>S 406 Based on recommendation from the ISDH surveyors, the following departments will have elements monitored for quality improvement as part of Adams Memorial Hospital's comprehensive quality assessment and improvement program (reported to Quality & Safety and Quality Council) and will go through the following approval process. Transcription Services (Contracted) · Inpatient H&Ps (without issues) will be transcribed within 2 hours of being dictated by the practitioner. *without issue indicated no technology issues Pediatrics · All pediatric charts ages 2-18 will be checked monthly for appropriate documentation of the pediatric child's height and weight during hospitalization. This information will be plotted on a growth chart. · All pediatric charts ages 0-2 will be checked monthly for appropriate documentation and measurement of the pediatric child's head circumference. Internal Laundry Service · All failed laundry processes will be monitored and logged. 10/9/2014- -Presented to the hospital Quality & Safety Committee to be added to the Hospital Quality Council PI Dashboard as a part of the</p>	10/22/2014

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	of the hospital's QA&I program. 3. At 11:00 AM on 8/28/2014, Quality/Risk/Compliance staff member #2 confirmed there were 5 services that had no documented evidence of being monitored and evaluated.		comprehensive quality assessment and improvement program . 10/15/2014—Presented to the hospital Quality Council from the Quality & Safety Committee 10/22/2014—Presented to hospital Board of Trustees by Quality Council Chairman The following departments will have elements monitored for quality improvement as part of Adams Memorial Hospital's comprehensive quality assessment and improvement program (reported to Medical Records/Utilization Review/PI and Medical Staff) and will go through the following approval process. EEG · EEG interpretations will be completed and dictated within 7 days of test administration date. EMG · EMG interpretations will be completed and dictated within 48 hours of test administration date. 10/7/2014—Presented to Medical Records/Utilization Review/PI committee to be added to the Medical Records/Utilization Review/PI—Medical Staff Dashboard as a part of the comprehensive quality assessment and improvement program . 10/21/2014—Presented to Medical Staff 10/22/2014—Presented to hospital Board of Trustees by Quality Council Chairman The Compliance Officer, Quality & Risk Manager will be responsible for this correction Completed by		

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to ensure a safe environment for patients by ensuring clean supplies and equipment were protected from contamination in patient care areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the Pre/Post-Op areas at 2:20 PM on 08/26/14, accompanied by staff member A6, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the clean linen storage area. 2. During the tour of the Obstetrical Unit at 3:10 PM on 08/26/14, accompanied by staff members A2 and A10, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the storage room. 3. During the tour of the Med/Surg Unit 	S000554	<p>10/22/2014 Please see Attachment-1A</p> <p>S 554 The following actions have been taken regarding the cardboard shipping boxes in clean supply areas. · 09/24/2014--Policy 906.045, Management of Dirty,Clean and Sterile Equipment/Supplies was updated to include specific language to ensure that clean supplies and equipment are protected from contamination inpatient care areas. Attachment 2A · 09/24/2014--An email reminder was sent to managers of departments that were cited as having cardboard shipping boxes. Managers were asked to ensure that all corrugated cardboard boxes are removed from clean storage room immediately. Attachment 2B · 09/26/2014--Clean storage rooms were inspected in all patient care areas with a department representative. Attachment 2C & 2D · Signs were posted in clean storage rooms reminding staff that outer shipping boxes and corrugated cardboard is not allowed</p>	09/26/2014	

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S000596	<p>at 9:35 AM on 08/27/14, accompanied by staff member A12, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the medication room.</p> <p>4. During the tour of the Intensive Care Unit at 10:30 AM on 08/27/14, accompanied by staff member A12, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the medication room and the clean supply room.</p> <p>5. During the tour of the Behavioral Health Unit at 11:15 AM on 08/27/14, accompanied by staff member A18, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies and clean linen in the clean supply room.</p> <p>6. At 1:00 PM on 08/27/14, staff member A1 confirmed the risk of cross-contamination to clean supplies from the outside shipping containers.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:</p>		Attachment 2E · This has been added to the Environmental Rounds form. Attachment 2F The Infection Preventionist is responsible for monitoring this plan of correction.				

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	<p>(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:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, documentation review, and staff interview, the hospital failed to disinfect physical care equipment with an hospital approved disinfectant for the Worthman Fitness Center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Cardiopulmonary Department policy #720.301.00 (last approved 2/2013) indicated all equipment shall be cleaned between patients by the rehab staff with a hospital approved disinfectant. At 2:00 PM on 8/27/2014, the Worthman Fitness Center was toured. The room had several pieces of fitness equipment that 	S000596	S 596 The following actions were taken in regards to cleaning solution used in the Worthman Fitness Center. · 08/27/14— immediately upon realization of this deficiency, the soap and water spray bottles were discarded and replaced with appropriately labeled spray bottles containing hospital approved cleaner. Attachment 3A · 09/24/14-The policy 720.301, Infection Control in Cardiopulmonary Rehab, was updated to include specific language indicating that it is the responsibility of the fitness center staff to ensure that equipment is cleaned between patient/member Attachment 3B · 09/24/14- -Fitness center staff were provided a copy of the updated policy. The staff were asked to read and review the policy. A sign off sheet was used to signify that staff reviewed the policy and are responsible for knowing and practicing the information provided. One staff member was off work during this time. This staff member is scheduled to	09/24/2014			

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	<p>were being used by patients and guests. The majority of the fitness equipment had a spray bottle hanging from them. The label on the spray bottles stated, "Water and Antibacterial Soap: Please use this solution to wipe off the exercise equipment."</p> <p>3. At 2:15 PM on 8/27/2014, rehab staff member #21 indicated the soap and water spray bottles are used between patient uses of the fitness equipment.</p> <p>4. At 3:15 PM on 8/27/2014, rehab staff member #24 indicated the Water and Antibacterial Soap spray solution was not an approved hospital disinfectant. The department has been working to find a disinfectant that kills pathogens and also does not deteriorate the equipment; however, the department dropped the ball and never finished looking for an approved hospital disinfectant.</p>		<p>work on 9/30/14 and will read and sign off on the policy at that time. Attachment 3C The Infection Preventionist is responsible for monitoring this plan of correction.</p>		

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, and interview, the</p>	S000912	S912 Based on medical record review, policy and procedure	09/04/2014
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	<p>nurse executive failed to ensure assessments were done according to policy and protocol for 3 of 3 patients seen in the Emergency Department (ED) (N11, N12, and N13).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical record for patient N11 indicated an ED visit on 05/16/14 with a chief complaint of vomiting blood. A set of vital signs was documented at 1145 with a triage category of non-urgent. The patient received medications for pain and nausea. The record lacked any further documentation of vital sign assessment prior to admission to the hospital at 1435. The medical record for patient N12 indicated an ED visit on 05/16/14 with a chief complaint of headache and abdominal pain. A set of vital signs was documented at 0851 with a triage category of non-urgent. The patient received medications for pain and nausea. The record lacked any further documentation of vital sign assessment prior to admission to the hospital at 1130. The medical record for patient N13 indicated an ED visit on 05/22/14 with a chief complaint of rectal bleeding. An incomplete set of vital signs (no temperature) was documented at 2052 		<p>review, and interviews, during the time of survey assessments were not done according to policy and protocol for 3 of 3 patients seen in the Emergency Department (ED). The following actions have been taken to correct this deficiency.</p> <p>09/03/2014-09/04/2014— Preliminary education was conducted at the September 3rd and 4th ED staff meeting to insure an immediate response to the concern noted during survey.</p> <p>09/26/2014--Policy "Assessment of the Emergency Department Patient" has been revised in an effort to eliminate fragmentation in the ED nursing record.</p> <p>10/1/2014-10/2/2014- -Implementation of a new CQI along with re-education to the new policy and CQI tool at ED staff meetings. This data will be added to the ED department PI dashboard and reported to Quality & Safety on a monthly basis for continued compliance for at least 3 months and thereafter quarterly. Data collection will begin 10/1/2014. Kevin Wellman, Director of Surgical & Emergency Services, will be responsible monitoring this action plan. Attachment 4A-C</p>	

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	<p>with a triage category of non-urgent. The patient was transferred to another facility at 2312 and the record lacked any further documentation of vital sign assessment, including in the designated area on the transfer form.</p> <p>4. The facility policy "Assessment of the Emergency Department Patient", last reviewed 04/2014, indicated, "1. All patients presenting to the Emergency Department will be triaged and categorized as emergent, urgent, or non-urgent. 2. All patients admitted to the Emergency Department will have the following documentation: ...c. Initial vital signs: i. Additional vital signs shall be obtained depending on the patient's condition. ii. Critical patients every 5-15 minutes as needed. iii. Intermediate patients every 1 hour. iv. All other patients every 2 hours."</p> <p>5. At 12:15 PM on 08/28/14, staff members A9 and A28, who were navigating the EMR (Electronic Medical Record), confirmed the records lacked documentation of vital sign assessment according to policy.</p>			

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S000936	<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.</p> <p>Based on documentation review and staff interview, the hospital failed to ensure 3 of 8 register nurses had documented competency in blood administration (N7, N9, and N10).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Eight registered nurse personnel files were reviewed for documented competency in fulfilling assigned responsibilities. Registered Nurses N7, N9, and N10 personnel files did not have documented evidence of competency in Blood Administration. At 10:00 AM on 8/28/2014, administrative staff member #27 confirmed there was no 	S000936	<p>S936</p> <p>Following review of several RN personnel files, it was determined that RN's N7, N9, and N10 did not have evidence of a competency in blood administration in their file at the time of survey. The following actions were taken to correct this deficiency.</p> <p>09/25-09/26/2014--Training to N7, N9, and N10 through our computer based education program with information provided by Lippincott (our on-line evidenced-based procedure manual).</p> <p>10/2/2014--In an effort to ensure all nursing personnel from the Medical-surgical, ICU, OB, BH, ED, OR ambulatory care units have evidence of this competency and skill. All personnel will have training through our computer based education program with information provided by Lippincott (our on-line evidenced-based procedure manual).</p> <p>This deficiency will further be prevented by including competency in blood</p>	09/26/2014

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S001028	<p>documented evidence that Registered Nurses N7, N9, and N10 had documented competency in blood administration.</p> <p>3. At 10:47 AM on 8/28/2014, Registered Nurse staff member #1 indicated all hospital Registered Nurses are required to demonstrate their competency in Blood Administration.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, interview, and policy and procedure review, the facility failed to ensure medications and prescription pads were secured to prevent unauthorized access in the nursery.</p>	S001028	<p>administration to departmental orientation process and annual skills training day for the following nursing units, Medical-surgical, ICU, OB, ED, OR ambulatory care. CNO will be responsible for monitoring this plan of correction. Attachment 5A-C</p> <p>S 1028 8/26/2014—Zippered pouches were obtained to store Emergency Medications for Neonatal Resuscitation on infant warmer. A numbered lock tag is used to secure the medications and the tag number is logged in</p>	08/28/2014

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the Obstetrical Unit at 3:10 PM on 08/26/14, accompanied by staff member A11, two storage devices with plastic pouches containing emergency supplies and medications (ex. Epinephrine and Sodium Bicarbonate) were observed hanging on the infant warmers. The medications were not secured in any way and easily accessible. Pads of prescription blanks were also observed in an unlocked drawer in the nursery. 2. At 3:15 PM on 08/26/14, staff member A11 confirmed that even though the door to the nursery was locked, it could be accessed by other staff members such as environmental services. He/she also confirmed other staff members could be in the nursery unsupervised by nursing staff and would have access to the medications and prescription pads. 3. The facility policy "Medication Management- Drug Storage", last reviewed 04/14, indicated, "O. No unauthorized persons will have unmonitored access and/or keys to either the pyxis units, and the medications contained within them, and/or the pharmacy department. All unauthorized personnel, i.e. drug reps or housekeeping, 		<p>nursery daily log. 8/26/2014—Prescription pads were removed from the drawer in the nursery and secured in the PYXIS machine. Only authorized personnel have access to the PYXIS machine. 8/28/2014—Staff Education provided at staff meeting. OB staff notified of state survey visit and steps taken to correct unlocked medications and prescription pads. Meeting minutes reflect discussion. OB staff members are recording green tag numbers on daily log, thereby noting securement of medication pouch. OB Department manager to monitor daily log for compliance. Director of Pharmacy and OB manager are responsible for monitoring this plan of correction. Attachment 6A-B</p>		

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	<p>etc. must be supervised by pharmacy personnel while in the pharmacy department. P. All medications will be kept secure and locked when appropriate in order to prevent diversion and tampering and to promote patient safety."</p> <p>4. The facility policy "Medication Management Emergency Drugs", last reviewed 04/2014, indicated, "Emergency drugs are maintained in an adequate amount to supply the hospital's needs. Emergency drugs are kept in an adequate supply in strategic locations throughout the hospital to be readily available when needed. The emergency drugs located throughout the hospital are kept in gray totes or red crash carts with tamper proof locks. The departments in which emergency totes or crash carts are kept are as follows: ...OB.... B. The emergency drugs within the tote/cart will remain inside, locked at all times when not in use. The cart/tote shall be stored in strategic areas so that they are under constant supervision."</p> <p>5. The facility policy "Medication Management Distribution of Medication to Patients at Discharge", last reviewed 04/2014, indicated, "Prescription pads will be locked up in a central location at all times on each floor/department when not in use by a physician."</p>			

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NAME OF PROVIDER OR SUPPLIER ADAMS MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 MERCER AVE DECATUR, IN 46733
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S001118	<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, staff interview and policy and procedure review, 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 three (3) instances: Emergency Department, Laboratory Obstetrical Unit .</p> <p>Findings included:</p> <p>1. Centers for Medicare and Medicaid Services considers the guidelines set by such sources as American National Standards</p>	S001118	<p>S1118 The EDdecontamination room was observed with an eyewash station-inspection tag thatindicated a monthly inspection rather than a weekly inspection. 9/1/2014—Maintenanceinitiated weekly inspections of the ED Decontamination eyewash station. Seeattachment 7A for weekly inspection form for September. 9/22/2014— Weeklyinspection tags were installed on the ED Decontamination eyewash station andshower. A new process was put into placeensuring that the decontamination room will be inspected every Monday morningby ED nursing personnel to insure that the eye wash and shower station is ingood working order. The weekly inspections will be recorded on the weeklyinspection tags. The MaintenanceSupervisor will</p>	09/22/2014
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	<p>Institute proper maintenance and weekly testing is necessary to ensure that Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines of sediment and bacteria build-up that is caused from stagnant water. The ANSI standard states that plumbed flushing equipment, "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available". Furthermore, the ANSI Z358.1-2009 standard also requires Portable and Self Contained equipment "be visually checked to determine if flushing fluid needs to be changed or supplemented".</p> <p>2. At 1:45 PM on 8/26/2014, the Emergency Department decontamination room was observed with an eyewash station. An inspection tag on the eyewash station was marked 12/28/(no year) and 6/12/(no year). At 3:00 PM. 1 hour and 15 minutes later, a new</p>		<p>maintain all records of the weekly inspections. Mark Harvey, Maintenance Supervisor will be responsible for monitoring this plan of correction. Attachment 7A -D</p>	

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	<p>inspection tag was on the eyewash station marked: 1/2014; 2/2014; 3/2014; 4/2014; 5/2014; 6/2014; 7/2014; and 8/2014. Therefore, the eyewash station was not noting the required weekly inspections.</p> <p>3. At 3:00 PM on 8/26/2014, Registered Nurse staff member #1 confirmed the inspections marked on the Emergency Department decontamination room eyewash station's inspection tag.</p> <p>4. At 1:45 PM on 8/27/2014, the eyewash station/shower combo was observed with an inspection tag noting monthly inspections. Therefore, the eyewash station/shower combo was not noting the required weekly inspections.</p> <p>5. At 9:45 AM on 8/28/2014, maintenance staff member #4 indicated all hospital eye wash stations are to be inspected monthly.</p>			

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	<p>6. During the tour of the Obstetrical Unit at 3:10 PM on 08/26/14, accompanied by staff member A11, a warming cabinet was observed in the nursery circ room. The bottom chamber contained blankets and the top chamber contained seven, 1000 ml. (milliliter) plastic bottles of Sterile Water. The temperature of the bottom chamber registered 126 degrees F. (Fahrenheit) and the top chamber registered 95 degrees F. None of the plastic bottles were date marked.</p> <p>7. At 3:15 PM on 08/26/14, staff member A11 indicated the warmed fluids were used for deliveries, but were not dated when they were placed in the warmer.</p> <p>8. The facility's policy "Warming Cabinets", issued 05/30/13, indicated, "The obstetrical, emergency, Med/Surg, and radiology (blanket warmer only) departments will maintain the following temperatures, fluid</p>			
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	rotation, daily temperature, and fluid monitoring on the warming cabinets in their respective departments. ...Upper Cabinet: The upper cabinet shall not exceed 100 F or 54.4 C at any time. Fluids stored in the cabinet will be dated with the date placed in the warmer; fluids stored in the warmer will not exceed 14 days."			