

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

PRINTED: 10/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33A246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH SETON PEDIATRIC CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>590 AVENUE OF THE AMERICAS NEW YORK, NY 10011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281 SS=D	<p><b>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interviews and record reviews it was determined that the facility did not ensure that residents with recurrent constipation are referred by the nursing staff to the physician for evaluation and treatment in accordance with the orders as evidenced by absence of documentation that a resident without bowel movements was referred to the physician for evaluation. These findings were noted in 1 of 24 residents (Resident #5).</p> <p>This resulted in no actual harm with the potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #5 is a 15 year old female with the following medical conditions: Lumbosacral myelomeningocele, status post ventriculoperitoneal shunt with multiple revisions, tracheostomy, gastrostomy tube, Arnold Chiari Malformation, neurogenic bladder, status post Nissen fundoplication, seizure disorder, bilateral myringotomy tube placement, constipation, scoliosis.</p> <p>On annual MDS 2.0 dated 9/9/07 section B 2 documented that the resident had memory problems and section B 4 documented cognitive skills for daily decision making was severely impaired.</p> <p>On 5/1/08, 5/30/08, 6/27/08, the physician</p>	F 281		8/25/08	

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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F 281	<p>Continued From page 1</p> <p>monthly orders include the following:</p> <p>Polyethylene glycol 3350 powder 17 grams (1 cap) measure via GT in flush at 6AM for 30 days (for constipation).</p> <p>Notify MD/NP if resident has not had bowel movement in 48 hours.</p> <p>Replete with Fiber 300ml every 6 hours at 300ml/hr. Water 300ml as bolus after feeds at 300ml/hr. On 5/30/08 and 6/27/08, the orders specified that the Replete with fiber and water were to be administered via gastrostomy tube at midnight, 6AM, noon and 6PM.</p> <p>The bowel movement record does not document any bowel movements on 6/1/08, 6/2/08, 6/3/08 and 6/4/08. One bowel movement is documented 6/5/08, 7 - 3 shift. There is no nursing or physician progress notes pertaining to the absence of bowel movements and there was no order for treatment in addition to the daily polyethylene glycol that she was receiving.</p> <p>The bowel movement record does not document any bowel movements on 6/20/08, 6/21/08, 6/22/08, 6/23/08. On 6/24/08 1 small bowel movement 11 - 7 shift and 1 bowel movement 7 - 3 shift are documented.</p> <p>On 6/23/08 at 3:40PM, adult glycerin suppository 1 pr (per rectum) X 1 for constipation was ordered.</p> <p>On 6/23/08 at 6PM, a nursing note indicates " Adult glycerin suppository given X 1 PR (per rectum) for constipation. No results noted. Abdomen soft non distended positive bowel</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>sounds. Endorsed to night shift in stable condition. "</p> <p>However, this treatment was ordered approximately 96 hours after the previous bowel movement and there was no physician ' s note pertaining to this episode of constipation.</p> <p>The bowel movement record does not document any bowel movements on 6/25/08, 6/26/08, 6/27/08. On 6/28/08 1 bowel movement was documented on the 7 - 3 shift.</p> <p>On 6/28/08 at 11PM, " Pediatric Fleet enema X 1 per rectal today (constipation) " was ordered and a physician ' s progress note documented that Fleet ' s enema was ordered for constipation. However, this treatment and the physician ' s evaluation occurred more than 72 hours after the previous bowel movement. On 6/28/08 a bowel movement was recorded.</p> <p>On 6/30/08 the " monthly nursing summary for June 2008 " states: " Elimination - resident was noted with 2 history of constipation this month - adult glycerin suppository was given with good result. " However, the nursing summary does not document the episode of constipation from 6/1/08 - 6/4/08 for which treatment in addition to polyethylene glycol was not ordered and the episode of constipation 6/25/08 - 6/27/08 for which Fleet ' s enema was ordered.</p> <p>The bowel movement record does not document any bowel movements on 6/29/08, 6/30/08, 7/1/08. On 7/2/08 one bowel movement was documented on the 7 - 3 shift.</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>There is no nursing or physician progress notes pertaining to the absence of bowel movements and there was no order for treatment in addition to the daily polyethylene glycol that she was receiving.</p> <p>The bowel movement record does not document any bowel movements on 7/3/08, 7/4/08, 7/5/08, 7/6/08. On 7/7/08 one small bowel movement was documented on the 11 - 7 shift.</p> <p>On 7/6/08 at 11:15AM " Adult fleet enema one P/R X 1 today (constipation) " was ordered.</p> <p>On 7/6/08 at 9:30PM a nursing note documents that " at 8:45PM, resident was given adult fleets enema per MD orders. . . As of this time no results "</p> <p>On 7/6/08 at 11:15am, a physician ' s note documented " constipation for 3 days. Adult fleet enema one P/R X 1 today. " However, this treatment and the physician ' s evaluation occurred approximately 96 hours after the previous bowel movement.</p> <p>On 7/7/08 at 6AM a nursing note documented " resident with small mucousy bowel movement. "</p> <p>On 7/17/08 at 5PM, the registered nurse/ charge nurse was interviewed and stated that if the resident has no bowel movements the certified nursing aide notifies the nurse who then notifies the physician usually within 48 hours.</p> <p>On 7/18/08 at 12 noon the director of nursing was interviewed and stated that the entire staff are informed every 24 hours about the bowel status for each resident. Every morning the physician</p>	F 281			

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F 281	Continued From page 4 participates in the rounds and decides on a case by case basis the treatment. Some children have bowel movements only every 5 days.  On 7/18/08 at 12:15PM a CNA was interviewed and stated that she was familiar with resident # 5 however she was not assigned to the resident during the 6/1/08 - 6/4/08 period. Although the resident had no bowel movements from 6/1 - 6/4, the resident was comfortable and a decision was made not to treat.  On 7/18/08 at 1PM, the attending physician was interviewed and stated that every morning during the week the physician and nursing staff make rounds and he is informed daily if the resident has missed bowel movements. He evaluates the resident. If the resident shows no signs of impaction and is comfortable, he may decide to observe the resident another day or 2 before ordering treatment. It can be ok to go 4 days without bowel movement.  However, nursing progress notes did not document that the attending physician was informed of the resident's constipation within 48 hours of the previous bowel movement.	F 281			
F 371 SS=D	415.11(c)(3)(i) 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		8/25/08	

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not ensure to store, prepare, distribute and serve food under sanitary conditions in that the kitchen environment was not maintained free of dust; also, the reach in refrigerators and walk in freezer lacked thermometers to indicate internal refrigeration temperatures. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.  The findings are:  During the annual inspection conducted on 07/16/08 between 9:00am and 3:30pm, the kitchen ceiling was observed not free of dust. Areas where dust was noted on the kitchen ceiling includes the light fixture close to the kitchen entrance door, the disposable good (paper cups) storage areas and on the ceiling tiles in the main food storage room. Also, it was observed that two reach in refrigerators and the walk in freezer lacked internal thermometers that would indicate refrigeration temperatures in the warmest parts of the units.  In an interview on 07/16/08 at approximately 9:50am, the Director of Nutrition stated that the dusty kitchen ceiling would be cleaned; she further added that thermometers would be provided in the reach in refrigerators and the walk in freezer.	F 371			
F 514 SS=D	415.14 (h) SubPart 14-1.44 483.75(l)(1) CLINICAL RECORDS	F 514		8/25/08	

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F 514	<p>Continued From page 6</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility did not ensure that the clinical record was accurately documented as evidenced by: not documenting a resident's allergy to a medication. This was evident for 1 of 24 sampled residents. (Resident #13).</p> <p>This resulted in no actual harm but with potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #13 is an 4 years old female with diagnoses which includes Chronic Lung Disease, Seizure Disorder, Cerebral Atrophy, and Severe Developmental Delay.</p> <p>The hospital discharge summary dated 9/4/07 documented that the resident experienced hives secondary to Morphine. It further documented that the resident had allergy/drug sensitivity to Morphine Sulfate.</p>	F 514			

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F 514	<p>Continued From page 7</p> <p>The physicians' orders dated 1/30/08 to 7/16/08 documented for allergies "NKA" (none known).</p> <p>The medication administration record dated 6/24/08 to 7/18/08 documented for allergies "NKA"</p> <p>On 7/17/08 at 6:30PM the RN (Registered Nurse) team leader was interviewed and stated that she reviewed this discharge summary but did not see that the resident experienced an allergic reaction to Morphine. The nurse further stated that the physicians' and nurses' are responsible for reviewing the discharge summary. She also stated that Morphine is suppose to be documented as an allergy for this resident.</p> <p>415.22(a)(1-4)</p>	F 514			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 33A246	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 9/12/2008
<b>Name of Facility</b> ELIZABETH SETON PEDIATRIC CENTER		<b>Street Address, City, State, Zip Code</b> 590 AVENUE OF THE AMERICAS NEW YORK, NY 10011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed 08/25/2008	ID Prefix <u>F0371</u> Reg. # <u>483.35(i)(2)</u> LSC _____	Correction Completed 08/25/2008	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 08/25/2008
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 7/18/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

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K 000	INITIAL COMMENTS	K 000		
K 046 SS=E	<p>42 CFR 483.70(a)</p> <p>The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: NFPA 101 section 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1½ hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>Based on interview and record review, it was determined that the facility did not ensure to test the battery-powered emergency lighting equipment at 30-day intervals for not less than 30 seconds and annually for not less than 1½ hours as evidenced by the facility ' s inability to provide records of visual inspections and tests for the battery-powered emergency lighting equipment. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p>	K 046		8/5/08

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K 046	Continued From page 1 The findings are:  During the annual LSC survey conducted 07/16/08 between 9:00am and 3:30pm, the facility was observed to be equipped with battery-powered emergency lightings in locations which include but are not limited to the clean utility room, laundry, material management store room, main electrical switch board room, hydrotherapy room and the generator room (all in the facility basement). While reviewing the maintenance logs on the same day at approximately 1:30pm, the facility was not able to provide documentation to show that the battery-packed emergency lightings were being inspected and tested from June 2007, as per requirements. A document was presented for emergency battery light fixtures for July 2008; however, the document did not indicate the type of test that was done on the emergency battery light fixtures.  In an interview with the Director of Facilities on the same day at approximately 1:50pm, he confirmed that the battery-powered emergency lightings should be tested as per requirement; he further added that the required test would be conducted henceforth.	K 046			
K 062 SS=B	711.2(a) (1) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		8/15/08	

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K 062	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: 2000 NFPA 101 Life Safety Code Chapter 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>9.7.1.1- Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>1999 NFPA 13 Chapter 5-5.6 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater.</p> <p>Based on observation and interview, it was determined that the facility did not ensure to provide the sprinkler system with the required clearance of 18 in. (457 mm) or greater between the sprinkler deflector and the top of storage. This resulted in no actual harm with potential for minimal harm.</p> <p>Findings are:</p> <p>During the annual LSC survey conducted on 07/15/08 (between 7:00pm and 11:00pm) and 07/16/08 (between 9:00am and 3:30pm), sprinkler heads were observed lacking the required clearance of 18 in. (457 mm) or greater between the sprinkler deflector and the top of storage in storage rooms which includes rooms 420, 504 and 529.</p>	K 062			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33A246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH SETON PEDIATRIC CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>590 AVENUE OF THE AMERICAS NEW YORK, NY 10011</b>		
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K 062	Continued From page 3 In an interview on 07/15/08 at approximately 9:30pm, the Director of facilities stated that storage will be relocated to ensure that sprinkler heads are provided with the required clearance of 18 inches between the sprinkler deflector and the top of storage.  2000 NFPA 101; 19.3.5, 9.7.1 1999 NFPA 13; 12-1 10 NYCRR 711.2 NYCRR 415.29	K 062			

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33A246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH SETON PEDIATRIC CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>590 AVENUE OF THE AMERICAS NEW YORK, NY 10011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I570	<p>713-2 Standards of Construction for New NH</p> <p>This Regulation is not met as evidenced by: REPEAT DEFICIENCY</p> <p>Physical Plant Violation - Stated Only NYCRR 713-2.2 (c)(6) Soiled workroom or soiled holding room. The soiled workroom shall contain a clinical sink or equivalent flushing rim fixture, sink equipped for hand washing, work counter, waste receptacle, and linen receptacle. A soiled holding room shall be part of an approved system for collection and disposal of soiled materials and shall be similar to the soiled workroom except that the clinical sink and work counter may be omitted.</p> <p>Based on observation, it was determined that the facility did not ensure to provide the soiled workrooms in the nursing units with work counters in addition to the other equipment required under this sub-section.</p> <p>The findings include:</p> <p>On 07/15/08 and 07/16/08 during the annual inspection, it was observed that the facility 's soiled workrooms on the 3rd, 4th, 5th and 6th floor nursing units lack work counters upon which work can be done. The 4th, 5th and 6th floors work soiled rooms were provided with mesh-like fixture (with holes measuring approximately 1.5in X 1.5in) suspended from the wall. These fixtures are not appropriate work fixtures upon which work can be done. This issue was identified in the previous survey of 07/05/2007 and the plan of correction stated that the Chief Engineer would have work counters installed in the soiled work rooms by the engineering staff to comply with the requirements of NYCCR 713-2.2 (c)(6).</p>	I570		8/31/08

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

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

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33A246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH SETON PEDIATRIC CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>590 AVENUE OF THE AMERICAS NEW YORK, NY 10011</b>		
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I570	Continued From page 1  On July 15, 2008, at approximately 10:10pm, the Director of Facilities confirmed that the mesh-like fixture provided on the 5th floor soiled workroom, with the aim of the facility complying with the code requirement as of previous survey, was not an appropriate work counter and further added that work counters would be installed in the soiled work rooms.	I570			

**State Form: Revisit Report**

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 2	<b>(Y2) Multiple Construction</b> A. Building <b>01 - MAIN BUILDING 01</b> B. Wing	<b>(Y3) Date of Revisit</b> 9/19/2008
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<b>Name of Facility</b> ELIZABETH SETON PEDIATRIC CENTER	<b>Street Address, City, State, Zip Code</b> 590 AVENUE OF THE AMERICAS NEW YORK, NY 10011
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>1570</u>	Correction Completed <u>08/31/2008</u>	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>713-2</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 7/18/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 33A246	<b>(Y2) Multiple Construction</b> A. Building <b>01 - MAIN BUILDING 01</b> B. Wing	<b>(Y3) Date of Revisit</b> 9/19/2008
<b>Name of Facility</b> ELIZABETH SETON PEDIATRIC CENTER		<b>Street Address, City, State, Zip Code</b> 590 AVENUE OF THE AMERICAS NEW YORK, NY 10011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <u>K0046</u>	Correction Completed <b>08/05/2008</b>	ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <u>K0062</u>	Correction Completed <b>08/15/2008</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

<b>Reviewed By</b> _____	<b>Reviewed By</b> _____	<b>Date:</b> _____	<b>Signature of Surveyor:</b> _____	<b>Date:</b> _____
<b>State Agency</b>				
<b>Reviewed By</b> _____	<b>Reviewed By</b> _____	<b>Date:</b> _____	<b>Signature of Surveyor:</b> _____	<b>Date:</b> _____
<b>CMS RO</b>				

<b>Followup to Survey Completed on:</b> 7/18/2008	<b>Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?</b> YES      NO
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