

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

PRINTED: 06/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335781	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/09/2009
NAME OF PROVIDER OR SUPPLIER RIVINGTON HOUSE THE NICHOLAS A			STREET ADDRESS, CITY, STATE, ZIP CODE 45 RIVINGTON STREET NEW YORK, NY 10002		
(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 309 SS=K	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to develop and implement policy and procedures to track and monitor laboratory orders and results. This resulted in a resident not receiving a PT/INR (Prothrombin Time/ International Normalized Ratio) test for two consecutive weeks as ordered, while receiving Coumadin (blood thinner)therapy. The resident presented with critical lab values, and then subsequently expired at the hospital due to a cerebral hemorrhage.</p> <p>This was evidenced in 1 of 4 sampled residents. (Resident is #1).</p> <p>This deficient practice has the potential to effect all residents that have physician's orders for laboratory blood work.</p> <p>This resulted in Immediate Jeopardy to resident health and safety.</p> <p>Complaint # NY00069038</p> <p>The findings are:</p> <p>Resident #1, age 52, was admitted to the facility</p>	F 309			

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

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(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 309	<p>Continued From page 1</p> <p>on 6/30/08. Admitting diagnoses included, Coronary Artery Disease, status post CABG (Coronary Artery Bypass Graft), and Hypercholesteremia. The Minimum Data Set 2.0 dated 10/16/08 noted that the resident had no memory or cognitive impairment.</p> <p>Resident #1 suffered a fracture of the right lateral malleolus on 10/10/08. On 12/11/08 a Venous Doppler screening revealed "thrombosis, right posterior tibial vein" and on 12/15/08 a physician order was written by the Nurse Practitioner (NP) for Coumadin therapy to be initiated. The NP ordered subsequent dosing adjustments and PT/INR testing as needed based on results.</p> <p>Review of the Interdisciplinary Progress Notes reveals a NP note written on 12/15/08 that states the resident is to begin receiving Coumadin 5 milligrams (mg).</p> <p>Review of the Medication Administration Record (MAR) for the resident reveals that as of 1/18/09, the resident was receiving 3 (mg) a day of Coumadin.</p> <p>On 1/28/09 the NP added an order onto the printed monthly Physician Order form requesting that PT/ INRs be done weekly on Mondays. A review of the laboratory results revealed that this NP order was carried out on Monday 2/2/09 with the results being PT=21.1 seconds (normal range is 10.0 -14.0) and INR =3.1 (normal range is 2.0-3.0 for residents on Coumadin therapy). On 2/9/09 the results were PT=20.9 and INR=3.1. This information is also confirmed on the resident's Anticoagulation Flow sheet which is filled out by the Physician or NP as the lab results are received and reviewed. Under the comments</p>	F 309			

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F 309	<p>Continued From page 2</p> <p>section on this flow sheet, the Nurse Practitioner noted that Coumadin dosage for Resident #1 should be maintained at 3mg per day.</p> <p>The NP was interviewed on 3/5/09 at 12:10 PM and again on 3/9/09 at 8:45 AM. He stated that he had decided to write a weekly order for PT/INRs for this resident because he had so many residents under his care and he did not want to forget to give the test to Resident #1. This was the first time he had written a standing order at this facility and was not aware of any specific procedure for standing orders (orders that are to be repeated at set intervals i.e. weekly, bi-weekly, etc. until discontinued by the physician). The Nurse Practitioner further stated that he spoke with the Unit Nurse and was instructed to have the Unit Clerk fill out a laboratory (lab) requisition form every Friday and place it in the " blood book, " which was a log maintained by the Unit Clerk for ordering blood tests. The NP stated that this procedure worked for the first 2 weeks Resident #1 was to get her PT/INR test, but does not know what happened after that.</p> <p>There is no documentation of any blood work done on Monday 2/16/09 and 2/23/09.</p> <p>During the interview, the NP on 3/5/09 at 12:10 PM, he stated that on 2/24/09 he examined the resident after she complained of cold symptoms. He checked the PT/INR flow sheet and noted that PT/INRs were not done for the prior 2 Mondays as ordered. He therefore ordered that blood work be done on 2/25/09. The NP further stated that he received a call on the evening of 2/25/09 from the laboratory and was told that the blood specimen obtained that day had clotted and the lab test could not be performed. He therefore requested</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>that another blood specimen be collected on the following morning, 2/26/09. On 2/26/09 at approximately 5:30 PM the NP received a call from the unit nurse stating that the laboratory had called-in the results of the resident's PT/ INR that were drawn that morning. The results were reported as PT = 96.1 seconds and INR= 57. These are considered critical values and are noted as abnormal high on the laboratory report. The Nurse Practitioner was not at the facility at the time and called the attending physician, who was still at the facility, to follow up in that these were critical readings.</p> <p>The attending physician was interviewed on 3/5/09 at 12:40 PM. He stated that he became aware of the elevated PT/INR on 2/26/09 at approximately 5:30 to 6:00 PM when he received the call from the NP and went to evaluate the resident. The resident showed no signs or symptoms of any bleeding and the resident herself denied having any symptoms. He contacted the laboratory and confirmed the results that were reported to him. Because the resident was asymptomatic, he decided to run the test again to confirm the results. He drew the blood specimen himself and handed it to the laboratory runner, who was at the facility.</p> <p>Review of the laboratory report documents the blood work result on the specimen drawn on 2/26/09 at 6:00 PM as PT =101.9 and INR=63.5. These are considered critical values.</p> <p>The Interdisciplinary Progress Note dated 2/26/09 at 11:10 PM documented that the results of the laboratory test were reported to the on call physician and he ordered that the resident be sent to the hospital. The on call physician also</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>ordered that 5mg Vitamin K be given intramuscularly immediately. The resident refused the Vitamin K and refused to be transferred to the hospital. She subsequently agreed to go to the hospital and left the facility via ambulette at 12:25 AM on 2/27/09. At this time, the resident was noted to be weak, lethargic and slow to follow instruction.</p> <p>The attending physician stated that he contacted the hospital on 2/27/09 and was informed that the resident had a documented prolonged PT/INR that was "unmeasurable" and the resident suffered a cerebral hemorrhage. The resident expired at the hospital on 3/1/09.</p> <p>The Unit Clerk was interviewed on 3/6/09 at 7:10 AM. She stated that she was responsible for submitting the weekly lab requisition forms for Resident #1. The Unit Clerk stated that on 2/20/09 the NP told her that the weekly PT/INR order was discontinued.</p> <p>However, during his interview on 3/9/09 at 8:45 AM, the NP denied telling the Unit Clerk that the laboratory orders were discontinued. He stated that he would have written an order to discontinue the lab work if that was the case.</p> <p>Review of the physician's orders form reveals that there are no orders to discontinue the weekly PT/INR lab work or the Coumadin.</p> <p>The Charge Nurse on duty on 2/26/09 from 3 PM through 11PM was interviewed on 3/6/09 at 5:45 AM. She stated that she was not aware that the resident had a weekly lab order. She also stated that standing orders were not written on any type of flow sheet. When she works the night shift</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>(11PM- 7AM), it is her responsibility to review any physician orders for the previous 24 hours only. She does not review any orders that were written prior to that time period. The Charge Nurse went on to state that about 3 years ago she was told that the physicians would write out all lab requisition forms so she assumed that if there were any orders, the physician would write out the form. This Charge Nurse also stated that she worked the night of 2/23/09 and reviewed Resident #1's chart for physician orders.</p> <p>According to the facility Policy and Procedure titled " Physician Orders: Transcriptions, " dated 12/01, when physician orders for blood work are received, the nurse is to place the order for blood work in the blood work book for the following day. The policy does not address who is responsible for filling out the laboratory requisition or how the requisition will be tracked to ensure that the tests ordered are done. Additionally, the policy did not address the implementation of standing orders.</p> <p>The Medical Director was interviewed on 3/5/09 at 11:25 AM. She stated that approximately three years ago the facility changed to a new laboratory for all blood work that was needed. At that time, she decided the best process for ordering blood work was for the Physicians and Nurse Practitioners to write out all lab requisition forms. She decided on this method because, in the past, she found discrepancies between what the physicians ordered and what nursing documented on the requisition forms. At that time, she verbally instructed all physicians that this was the new policy. The Medical Director was asked if there was a written policy on this change and she responded that she had been working on rewriting the policy, but there was no written</p>	F 309			

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F 309	<p>Continued From page 6 policy at the present time.</p> <p>All seven nursing units were toured on 3/5/09 and 3/6/09. All units had a phlebotomy book which is called the "blood book" yet procedures for carrying out the physician orders for lab work were different on each unit. Examples include:</p> <p>The Charge Nurse on Unit 3 West was interviewed on 3/5/09 at 3:15 PM and stated that the physician fills out the lab requisition form and puts it in the blood book. The night nurse is required to check the orders and write any lab requisitions that were missed by the physician. There are no tracking sheets used on this unit. The Charge Nurse could not state how the unit was able to ensure that standing orders were completed as ordered;</p> <p>The Charge Nurse on Unit 4 West was interviewed on 3/5/09 at 4:00 PM and stated that sometimes the physician will write the lab requisition form and sometimes the nurse will write it. They will fill out the "Daily Blood Work" sheet. If it is a weekly standing order, the nurse who picks up the order is required to enter this on the Medication Administration Record (MAR) so that the nurse on duty when the order is to be drawn will be aware of it. It is the responsibility of the nurse at that time to fill out the requisition form and place it in the blood book;</p> <p>The Charge Nurse and LPN on Unit 4 East were interviewed on 3/5/09 at 4:05 PM. The Charge Nurse stated that it is incumbent upon the physician to fill out the lab requisition form and it is the responsibility of all the nurses to check that blood work was done. The LPN added that it was the physician's responsibility to write a lab</p>	F 309			

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F 309	Continued From page 7 requisition form every week for standing orders; The Charge Nurse on 5 West during the evening shift was interviewed on 3/5/09 at 3:50PM. She stated that the night or morning nurse is responsible for checking that the lab requisition forms for lab work required that day are filled out and placed in the blood book; and The Charge Nurse on 5 West during the night shift was interviewed on 3/6/09 at 5:25 A.M. She stated that the lab requisition forms are usually done by the staff on the 4PM to 12 AM shift. A review of the blood book on the nursing unit where Resident #1 was located, Unit 3 West, revealed that a blank Interdisciplinary Progress Note sheet was placed at the front of the book. On it was written, in large printed letters, "SPECIAL LAB REQUEST." Resident #1's name was listed and next to it was written "PT/INR on Mondays". There are no signatures/initials as to who wrote this on the form, no dates and no tracking as to when the tests were done. The only other notation is a statement that indicates it was discontinued on 2/26/09. The physician's orders form also document that the Coumadin was discontinued on 2/29/09. There is no system in place to ensure that all physician laboratory orders, specifically standing orders, are completed. There is no system identifying who is responsible to ensure that the requisition forms are completed and no system to follow- up to ensure that the lab work was actually done.	F 309			
F 490	415.12 483.75 ADMINISTRATION	F 490			

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F 490 SS=K	Continued From page 8 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The Administrator failed to ensure that the facility operates in a manner in which its policies are developed, implemented, and checked for effectiveness. There is no policy in place to ensure that standing orders for blood work are carried out. The Administrator was interviewed on 3/5/09 at 11:15 AM and stated that there is no written policy for the handling of standing orders. He further stated that each nursing unit has its own procedure for handling of standing orders but there is no policy. See F-309-K	F 490			
F 501 SS=K	415.26 483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	F 501			

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F 501	<p>Continued From page 9</p> <p>The Medical Director failed to be involved in the development, review and implementation of resident care policies that address laboratory blood work, specifically standing orders.</p> <p>The Medical Director was interviewed on 3/5/09 at 11:25 AM. She stated that approximately three years ago the facility changed to a new laboratory for all blood work that was performed. At that time, she decided it would be best if the Physicians and Nurse Practitioners were responsible for writing all lab requisition forms. She decided this because, in the past, she had discovered discrepancies between what tests the physicians ordered and what nursing actually requested on the requisition forms. At that time, she verbally instructed all the physicians that this was the new policy. The Medical Director was asked if there was a written policy documenting this change and she responded that she had been working on rewriting the policy, but there was no written policy at the present time.</p> <p>The Medical Director also stated that there was no policy and procedure for standing orders. She further stated that each unit was responsible for implementing their own system. The Medical Director also stated that she had not been involved in developing any policy and procedure for standing orders.</p> <p>See F-309-K</p> <p>415.15(a)</p>	F 501			

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{F 501} SS=E	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	{F 501}			

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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.

(Y1) Provider / Supplier / CLIA / Identification Number 335781	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/6/2009
Name of Facility RIVINGTON HOUSE THE NICHOLAS A	Street Address, City, State, Zip Code 45 RIVINGTON STREET NEW YORK, NY 10002	

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>F0309</u>	Correction Completed <u>03/30/2009</u>	ID Prefix <u>F0490</u>	Correction Completed <u>03/30/2009</u>	ID Prefix <u>F0501</u>	Correction Completed <u>03/30/2009</u>
Reg. # <u>483.25</u>		Reg. # <u>483.75</u>		Reg. # <u>483.75(i)</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
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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: 3/9/2009	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		