NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

tchester Medical Center	PAGE 1 of 10
sslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

: The following list of deficiencies was identified by th Department Representative during the survey of your lity. Correction of these deficiencies is required in r to bring your facility into compliance with the State ew York Official Compilation of Codes, Rules and lations (10NYCRR). In the column headed Provider's Plan orrection, describe the plan of corrective action and the cipated date of correction.

vestigation of
[redacted]
edical Record #1)

5.2 Governing body

) Organization and Operation

) The governing body, in order to hieve and maintain generally cepted standards of professional actice and patient care services in e hospital, did not establish, use to implement, maintain and, as cessary, revise its practices, licies and procedures for the going evaluation of the services erated or delivered by the hospital d for the identification, sessment and resolution of problems at may develop in the conduct of ie hospital.

lequate safety precautions were not iplemented and maintained on '27/01, when a ferrous oxygen inister was introduced into the ignetic resonance imaging (MRI) rocedure room and drawn by the rong magnetic force into the MRI anner's tunnel, striking a sedated tient, a six year old child, sulting in fatal injuries. The llowing issues contributed to the itcome of the incident.

procedure had not been established o ensure an adequate, uninterrupted upply of oxygen during the use of naesthetics while an MRI process was ccurring. On 7/27/01, the piped-in xygen supply became depleted at the

405.2 Governing body
(b) (2) Organization & Operation

The governing body, in order to achieve and maintain generally accepted standards of professional practice and patient care services in the hospital will establish, cause to implement, maintain and, as necessary revise its practices, policies and procedures for the ongoing evaluation of the services operated or delivered by the hospital and for the identification, assessment and resolution of problems that may develop in the conduct of the hospital as evidenced in this plan of correction which addresses the hospital's quality assurance program to include patient care services rendered on site by a private entity or provided pursuant to a contractual agreement. Reference 405.6(a)(2)(i-vii)

The plan of correction also addresses the implementation and development of a program designed to adequately eliminate safety hazards including equipment necessary to supply oxygen safely during the MRI procedure (reference 405.7 (b)(3) and maintenance of safety zones to control introduction of ferrous material into the MRI area.

The monitoring activities resulting from implementation of measures taken pursuant to this plan of correction will be reported to and evaluated by the Quality Improvement Committee, EPIC and the Quality Care Group of the Board of Directors.

Acceptable
10/10/01
JR

:stchester Medical Center	PAGE 2 of 10
:asslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

ɔmmencement of the MRI procedure on ıe sedated patient. After the ıesthesiologist identified an ısufficient flow of the piped-in ‹ygen, he insistently notified an ʁI technician that there was a roblem with the piped-in oxygen ıpply. Then, both technicians, who ɔuld otherwise be present in the MRI ɔntrol room, left the control room ıd went to an adjacent room that ɔuses the piped-in oxygen supply anks.

lthough informed by the technician ıat the problem with the piped-in xygen supply would be addressed, ıortly thereafter the ıesthesiologist again urgently alled out to obtain oxygen. While ɔth MRI technicians were attending ɔ the piped-in oxygen equipment in he other room, the anesthesiologist btained a small, portable, ferrous xygen tank from outside the scanning rocedure room and brought the tank nto the MRI scanning room. The ɔrtable tank was then drawn by the trong magnetic force into the MRI canner's tunnel, striking the edated patient.

ith both MRI technicians out of the ontrol room to attend the issue of he depleted oxygen supply, the canner and related equipment were eft unsupervised, and the echnicians were out of direct view f the sedated child who had been laced in the scanner's tunnel. The bsence of these staff in the control oom, as the ferrous oxygen canister as being introduced into the MRI canning procedure room, circumvented n opportunity to prevent the ransfer of the inappropriate oxygen ank into the procedure room.

Westchester Medical Center	PAGE 3 of 10
Grasslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

The hospital had not developed and implemented a program designed to adequately eliminate safety hazards. At the time of the 7/27/01 incident, small, portable ferrous oxygen tanks were being stored in an alcove within the MRI suite, across from and in the immediate proximity of the MRI scanning procedure room. It was one of these readily available tanks that was introduced into the MRI scanning procedure room when the anesthesiologist was attempting to obtain additional oxygen, in response to the depletion of the piped-in oxygen supply.

A similar incident occurred in the same MRI suite in 1997, wherein a ferrous oxygen tank was introduced by an anesthesiologist into the scanning procedure room, and was then magnetically drawn and struck the imaging device. Although an incident report was written by staff of the private entity that was then operating the MRI equipment, that report was not submitted to appropriate administrative staff, and therefore not addressed through the hospital's Quality Assurance Program. Due to the failure in obtaining the 1997 incident report, the potential problem was not further assessed, and the hospital did not revise its practices, policies and procedures for the ongoing evaluation of the MRI services operated by the hospital.

Reference is made to citations under [redacted] and 405.7(b)(3).

(f) Care of Patient

(1) Every patient of the hospital, whether an inpatient, emergency services patient, or outpatient, was not provided care that met generally

(f) Care of Patient

(1) Every patient of the hospital whether an inpatient, emergency services patient, or outpatient will be provided care that meets generally acceptable standards of professional practice.

Reference is made to 405.4 (a)(1)(ii) wherein the medical staff will establish objective standards of care consistent with prevailing standards of medical and other licensed health care practitioner standards practice and conduct of medical care.

Reference is made to 405.7 (b) (3) the hospital will afford each patient considerate and respectful care in a safe environment. The hospital will provide service in a safe and protective manner and the staff will ensure that the equipment needed for the procedure is available.

The hospital is outfitted with a central piped oxygen and medical air system. The system is annually inspected and certified for proper function and safety by Respiratory Management Systems including all alarms. The MRI area is now connected to the central system and, at installation, outlets in the MRI area were tested and certified. The hospital wide system includes an alarm system, which is centrally managed by remote alarm panels in Security which is manned 24 hours a day. If an alarm is activated, Security notifies on-site respiratory therapy supervision.

The hospital wide oxygen system includes zone pressure gauges, which have been installed in the MRI area. The gauges indicate PSI for oxygen and medical air and vacuum used for suction. Oxygen is maintained at a line pressure of 50 PSI.

Monitor: The central piped oxygen and medical air system includes a remote alarm panel located in the Security Department. Security will log if the alarm is activated. Respiratory Therapy will maintain a log of response to notification by security for 3 months. Monitoring to be reported to the EPIC committee.

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

estchester Medical Center	PAGE 4 of 10
casslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION
ceptable standards of professional ractice. patient, a six year old child, ffered fatal injuries during an MRI rocedure, when on 7/27/01 a ferrous xygen canister was introduced into ne procedure room and drawn by the trong magnetic force into the MRI canner's tunnel, striking the edated patient. eference is made to citation under 05.4(a)(1)(ii). 7) The hospital did not have vailable at all times personnel ufficient to meet patient care eeds. Although appropriate staff ere assigned on 7/27/01 to perform he MRI procedure, at the time of the ncident adequate staff were not resent at the MRI's control room to onitor the activity within the MRI canning procedure room, and were herefore not immediately available o attempt intervention measures to ossibly prevent/lessen the injury to he patient. At the time the ferrous xygen canister was introduced into he magnetic resonance imaging (MRI) rocedure room, both MRI technicians ad left the control room to attend o the issue of the depleted oxygen upply, thereby leaving the scanner nd related equipment unsupervised, nd placing them out of direct view f the sedated child that had been laced in the scanner's tunnel. The bsence of these staff in the control oom circumvented an opportunity to revent the transfer of the ferrous xygen tank into the procedure room.	(f)(7) To assure adequate staff are available to intervene to avoid and/or limit patient injury in the MRI area, the new MRI area is designed to assure continuous supervision and monitoring of activity by MRI staff of the control room, scanner, and related equipment and direct view of the patient in the magnet. (See diagram) See section 405.7 (b) (3) which describes provision of oxygen for patients during the MRI procedures eliminating the need for MRI staff to leave the control room to address oxygen supply for patient during an MRI procedure. Monitor: The central piped oxygen eliminates using H tanks for the oxygen source for patients during MRI procedures. See diagram for new area which allows for continuous supervision and monitoring of activity by MRI staff of the control room, scanner, and related equipment and direct view of the patient in the magnet and see 405.7(b)(3) for monitoring. Acceptable 10/10/01 JK

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Westchester Medical Center	PAGE 5 of 10
Grasslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

405.4 Medical staff

(a) Medical Staff Accountability

(1)(i) The medical staff did not establish objective standards of care, consistent with prevailing standards of medical and other licensed health care practitioner standards of practice and conduct of medical care.

On 7/27/01, prior to commencing the MRI scan, but while the patient was lying in the scanning chamber under sedation, the anesthesiologist identified an insufficient flow of the piped-in oxygen. The anesthesiologist insistently notified an MRI technician that there was a problem with the piped-in oxygen supply.

Although informed by the technician that the problem with the piped-in oxygen supply would be addressed, shortly thereafter the anesthesiologist again urgently called out to obtain oxygen. While both MRI technicians were attending to the piped-in oxygen equipment in the other room, the anesthesiologist obtained a small, portable, ferrous oxygen tank from outside the scanning procedure room and brought the tank into the MRI scanning room. The portable tank was then drawn by the strong magnetic force into the MRI scanner's tunnel, striking the sedated patient.

(1)(ii) The medical staff did not afford patients their rights as patients in accordance with the provisions of this Part. Reference

405.4 Medical Staff
(a) (1) (i) Medical Staff Accountability

The medical staff will establish objective standards of care consistent with prevailing standards of medical and other licensed health care practitioner standards of practice and conduct of medical care.

When the presence of an anesthesiologist is required for patient care during MRI scanning, communication between the physician in the scan room and the MRI tech in the control room is facilitated by an enhanced communication system installed in the new magnet with sensitive microphone capabilities.

Initial testing of the enhanced communication system demonstrated that the physician could be clearly heard by the technicians in the console room regardless of position and/or distance. Quarterly testing of the will be conducted by senior staff to identify and resolve any communication issues. Results will be reviewed by the Radiology CQI Committee and reported to QCRM.

(1) (ii) The medical staff will afford patients their rights as patients in accordance with the provisions of this part.

Reference is made to 405.7-(b) (3) for a description of provision of oxygen to patients during the MRI provisions. (See related monitoring)

Acceptable
10/10/01
JR

estchester Medical Center	PAGE 6 of 10
rasslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

s made to citation under
05.7(b)(3).

05.6 Quality Assurance Program

[redacted]

405.6 Quality Assurance Program

[redacted]

Accepted
10/10/01

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

stchester Medical Center	PAGE 7 of 10
asslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

[redacted]

05.7 Patients' Rights

b) Hospital Responsibilities

3) The hospital did not afford this atient considerate and respectful are in a safe environment.

he hospital did not provide service n a safe and protective manner, when he staff did not ensure that the quipment needed for the procedure as available for use.

[redacted]

Acceptable 10/10/01 JR

405.7 Patient Rights
(b) (3) Hospital Responsibilities

The hospital will afford patients considerate and respectful care in a safe environment. The hospital will provide service in a safe and protective manner, and the staff will ensure that the equipment needed for the MRI procedures is available for use.

The hospital is outfitted with a central piped oxygen and medical air system. The system is annually inspected and certified for proper function and safety by Respiratory Management Systems including all alarms. The MRI area is now connected to the central system and at installation outlets in the MRI area were tested and certified. The hospital wide system includes an alarm system, which is centrally managed by remote alarm panels in Security which is manned 24 hours a day. If an alarm is activated, Security notifies on-site respiratory therapy supervision.

The hospital wide oxygen system includes zone pressure gauges, which have been installed in the MRI area. The gauges indicate PSI for oxygen and medical air and vacuum used for suction. Oxygen is maintained at a line pressure of 50 PSI.

Monitor: See diagram for zoning
Security Zones policy and procedures will be reviewed at all general orientation sessions, reviewed by hospital departments at staff meetings and presented at medical staff orientation.

Acceptable 10/10/01 JR

stchester Medical Center	PAGE 8 of 10
asslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

e staff did not have in place a chanism regarding the piped-in ygen tanks, utilized at the mmencement of the MRI procedure on e sedated patient, to indicate the ount of oxygen available in the nk. The agitation of a little red ll gauge, attached to the flow ter within the scanning procedure om, only indicated that there was t oxygen flow, rather than the ount of oxygen readily available. the time of the 7/27/01 event, ly one tank was connected to the ped-in oxygen system, and it had ptied during at just the mmencement period of the procedure.

~~5.13 Anesthesia Services~~

) Operation and Service Delivery

) (iii) All anesthesia care was not ovided in accordance with accepted andards of practice and in a manner ensure the safety of the patient ring the administration and conduct anesthesia.

lequate safety precautions were not plemented and maintained on 27/01, when a ferrous oxygen nister was introduced into the gnetic resonance imaging (MRI) ocedure room and drawn by the rong magnetic force into the MRI anner's tunnel, striking a sedated tient, a six year old child, sulting in fatal injuries.

5.15 Radiologic and Nuclear dicine Services

) Safety for Patients and Personnel

) The radiologic services were not ee from hazards for patients and

405.13 Anesthesia Services
(a) (2) (iii) Operation and Service Delivery

Anesthesia care will be provided in accordance with accepted standards of practice and in a manner to ensure the safety of the patient during the administration and conduct of anesthesia; refer to section 405.7 (b)(3) describing delivery of oxygen to patients during MRI procedures, refer to section 405.24 (a) for a description of secure zones and control of equipment entering the restricted areas and refer to 405.24 (j)(2) for procedures to transfer patients requiring oxygen from a ferrous tank to an MRI compatible tank.

Monitor: See noted sections for monitoring.

405.15 Radiologic and Nuclear Medicine Services
(a) (3) Safety for Patients and Personnel

The new MRI area is designed to assure continuous supervision and monitoring of activity by MRI staff of the control room, scanner, and related equipment and direct view of the patient in the magnet.

The hospital will afford patients considerate and respectful care in a safe environment. The hospital will provide service in a safe and protective manner, and the staff will ensure that the equipment needed for the MRI procedures is available for use.

Monitor: Refer to 405.7 (b)(3) (Central system)
Refer to 405.6 (a)(1)(iv) (Security Zones)

Acceptable 10/10/01

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

stchester Medical Center	PAGE 9 of 10
asslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

rsonnel. Written policies and ocedures affecting safety were adequate, and those in writing were t followed.

e policy related to the oxygen pply was not written, resulting in tential for inconsistent derstanding and administration of ygen. Therefore, the staff had no tablished guidelines to follow. A ocedure had not been established to sure that an amount of oxygen, equate for an uninterrupted supply ring the use of anaesthetics, would available in the piped-in supply nk while an MRI process was curring. On 7/27/01, the piped-in ygen supply became depleted at the ~~mmencement of the MRI procedure on e sedated patient, precipitating~~ a ed for the technicians, who would herwise be present in the MRI ntrol room, to go to another room manually install a replacement ygen cylinder.

the time of the actual incident, th MRI technicians had left the ntrol room to attend the issue of ie depleted oxygen supply, thereby aving the scanner and related uipment unsupervised, and placing iem out of direct view of the dated child who had been placed in ie scanner's tunnel. The absence of iese staff, as the ferrous oxygen inister was being introduced into ie MRI scanning procedure room, rcumvented an opportunity to itervene in the inappropriate oxygen ink being brought into the procedure oom.

405.24 Environmental Health
(a) Buildings and Grounds

The facility grounds and buildings will be maintained in functional condition to meet the design intent, free of safety hazards, that may adversely affect the health or welfare of patients.

The new MRI area has 3 designated zones. Zone 3, the most restricted area includes the magnet room, the control area and the computer room. This highly restricted area is under the direct supervision of MRI personnel. Access to zone 3 is controlled by a locked door and MR personnel control entry into this zone. Zone 2 is an area for interface between the public area zone 1 and consists of an anteroom adjacent to zone 3. The area used for preparation and resuscitation as necessary. Access to zone 2 and 3 is keyed with all keys held by only MRI personnel and only MR technicians have a key to zone 3. Signs are clearly visibly on the locked doors. Zone 1 an area outside the MRI suite down a corridor is located in the radiology staging area. It is accessible to the public and any health care professional.

The hospital is outfitted with a central piped oxygen and medical air system. The system is annually inspected and certified for proper function and safety by Respiratory Management Systems including all alarms. The MRI area is now connected to the central system and at installation outlets in the MRI area were tested and certified. The hospital wide system includes an alarm system, which is centrally managed by remote alarm panels in Security which is manned 24 hours a day. If an alarm is activated, Security notifies on-site respiratory therapy supervision.

The hospital wide oxygen system includes zone pressure gauges, which have been installed in the MRI area. The gauges indicate PSI for oxygen and medical air and vacuum used for suction. Oxygen is maintained at a line pressure of 50 PSI.

Monitor: Refer to 405.7 (b)(3) (Central system)
Refer to 405.6 (a)(1)(iv) (Security Zones)

Acceptable 10/10/01 JR

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Westchester Medical Center	PAGE 10 of 10
Grasslands Reservation, Valhalla, NY 10595	Survey Date: 7/31/01

DEFICIENCIES AND 10NYCRR CITATIONS	PROVIDER'S PLAN OF CORRECTION

405.24 Environmental Health

(a) Buildings and Grounds

(1) The facility grounds and building were not maintained in functional condition to meet the design intent, free of safety hazards, that may adversely affect the health or welfare of patients.

The "safety zone" around the scanner area, to designate the area within which metallic items must not be introduced, was not clearly identified, except for the inadequate signs at the entrance to the MRI area and the scanner room.

There was no automatic indicator or alarm device for alerting the staff of the insufficient oxygen availability from the piped-in supply. Additionally, at the time of the 7/27/01 incident, the facility lacked an established safety parameter regarding when the main, piped-in oxygen supply tank(s) needed to be replaced.

(j) Injury Control

(2) The hospital had not developed and implemented program designed to eliminate safety hazards.

At the time of the 7/27/01 incident, small, portable ferrous oxygen tanks were being stored in an alcove within the MRI suite, across from and in the immediate proximity of the MRI scanning procedure room. It was one of these readily available tanks that was introduced into the MRI scanning procedure room when the anesthesiologist was attempting to obtain additional oxygen, in response to the depletion of the piped-in oxygen supply.

(j) (2) Injury Control
The hospital will develop and implement a program designed to eliminate safety hazards to assure that MRI compatible equipment is utilized in the scanning room, which is zone 3. The MRI technician controls equipment allowed into the scanning room.

If an inpatient requires oxygen during transport they will be met by MR personnel who will transfer the patient to a MRI compatible oxygen system, and then escort the patient into Zone 2: an area of interface between the publicly accessible Zone 1 and the highly restricted Zone 3.

Outpatients requiring supplemental oxygen who bring their own ferrous vessels will be met in Zone 1 by MR personnel who will transfer the patient from a ferrous vessel to a non-ferrous vessel, and then escort the patient to Zone 2. The patient will be asked to store their personal tank in their automobiles. When the MRI examination is completed, the switch back to the patient's personal oxygen vessel will take place in Zone 1. Any discrepancy as to whether or not the patient's personal oxygen vessel is MRI compatible will be handled by MR personnel as if it were a ferrous object. If the patient is unable to store their oxygen vessel in their automobile, MRI personnel will ensure its safely within Zone 1 during the procedure.

Monitor: Security Zones policy and procedures developed will be reviewed at all general orientation (general orientation scheduled meetings), reviewed by hospital departments at staff meetings and presented at medical staff orientation.

Daily inspection rounds using a checklist to identify items including zone pressure gauges in the MRI area presenting safety risk in zones 2 and 3. The list to be maintained in the MRI Department and reviewed quarterly by Radiology CQI and reported to EPIC.

Acceptable 10/10/01 JR

STATE OF NEW YORK : DEPARTMENT OF HEALTH

IN THE MATTER

OF

ANTONIA C. NOVELLO, M.D., M.P.H., Dr. P.H., as Commissioner of Health of the State of New York, to determine the action to be taken with respect to:

WESTCHESTER COUNTY HEALTH CARE CORPORATION

Respondent,

as operator of

WESTCHESTER MEDICAL CENTER
Grasslands Reservation
Valhalla, NY 10595

STIPULATION

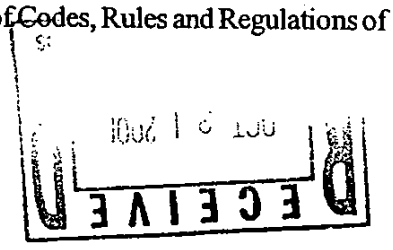
AND

ORDER

BHS-01-04

arising out of alleged violations of Article 28 of the Public Health Law of the State of New York and Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR).

WHEREAS, the New York State Department of Health (the "Department") has conducted surveys and inspections of WESTCHESTER MEDICAL CENTER, operated by WESTCHESTER COUNTY HEALTH CARE CORPORATION (the "Respondent") and has found alleged violations of Article 28 of the Public Health Law and Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR); and



WHEREAS, a Statement of Deficiencies resulting from the Department's inspection on July 31, 2001 was issued to the Respondent on September 26, 2001; and

WHEREAS, prior to commencement of administrative enforcement action based upon the alleged violations by service of a Notice of Hearing and Statement of Charges, the Department and the Respondent engaged in settlement discussions; and

WHEREAS, the parties wish to resolve this matter by means of a settlement instead of an adversarial administrative hearing.

NOW, THEREFORE, IT IS STIPULATED AND AGREED AS FOLLOWS:

1. The matter relating to alleged violation of Article 28 of the Public Health Law and 10 NYCRR, as set forth in the Statement of Deficiencies, dated September 26, 2001 is settled and discontinued with prejudice upon the terms and conditions set forth in this Stipulation and Order.

2. The Respondent, for the purpose of resolving this administrative matter only, admits the existence of substantial evidence of violations of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, as set forth in the bracketed and numbered portions of the Statement of Deficiencies, dated and issued on September 26, 2001, a copy of which is attached to and made a part of this Stipulation and Order as Attachment A.

3. The Respondent is assessed a civil penalty of Twenty-Two Thousand Dollars ($22,000) and shall pay the entire amount of that sum within fifteen (15) days of the effective date of this Stipulation and Order.

4. Payment shall be sent by certified mail, return receipt requested, and shall be made payable by certified check to the New York State Department of Health, Bureau of Accounts Management, Corning

Tower, Room 1258, Empire State Plaza, Albany, New York 12237-0016.

5. Any civil penalty not paid in accordance with this Stipulation and Order shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection and non-renewal of permits or licenses. [Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32].

6. The Department, in determining whether there has been non-compliance with the terms of this Stipulation and Order, shall consider whether the Respondent has made good faith efforts to comply, and the Department shall take into consideration any matter beyond the control of the Respondent which may have caused non-compliance. However, the Respondent's obligations under this Stipulation and Order shall remain in full force and effect until the Respondent achieves full compliance with every item required.

7. The Respondent shall develop, submit and implement an acceptable Plan of Correction responding to the Statement of Deficiencies issued on or about September 26, 2001 within time frames acceptable to the Department and subject to monitoring by the Department's New Rochelle Area Office.

8. The Respondent shall submit quarterly progress reports to the Department on each of the components of this Stipulation and Order for a one-year period commencing with the effective date of this Stipulation and Order. These reports shall detail activities undertaken to implement corrective actions and an assessment of the effectiveness of these corrective actions.

9. It is further stipulated and agreed by the Respondent and the Department that there exist valid and sufficient grounds as a matter of fact and law for the issuance of this Stipulation and Order under the Public Health Law and the Respondent consents to its issuance, accepts its terms and conditions and waives any right to challenge or review this Stipulation and Order through administrative or judicial proceedings, including a proceeding pursuant to Article 78 of the Civil Practice Law and Rules.

10. The foregoing admissions made by the Respondent in this Stipulation and Order are solely for the purpose of resolving the instant administrative matter and are not intended for use in any other forum, tribunal or court outside the Department, including any civil or criminal proceedings in which the issues or the burden of proof may differ. Further, any such admissions are without prejudice to the Respondent's rights, defenses and claims in any other matter, proceeding, action, hearing or litigation not involving the Department. It is further agreed that the Department's allegations address violations of standards contained within Title 10 NYCRR Part 405 ("Hospitals - Minimum Standards") and are not intended to be dispositive of allegations of medical malpractice, negligence or other tort, as might be made in a civil action for monetary damages.

11. This Stipulation and Order shall be effective upon service on Respondent or Respondent's attorney or representative of a copy by personal service or by certified or registered mail.

DATED: Valhalla, New York
October 12, 2001

WESTCHESTER COUNTY HEALTH CARE CORPORATION

BY: _____

AGREED AND SO ORDERED:

DATED: Albany, New York
10-19, 2001

ANTONIA C. NOVELLO, M.D., M.P.H., Dr. P.H.
Commissioner of Health

BY: _____
DENNIS P. WHALEN
Executive Deputy Commissioner

Inquiries To: Michael P. Weinstein, Esq.
Phone # (518) 473-5172
FAX # (518) 486-1858

Mail Payment To:

New York State Department of Health
Bureau of Accounts Management
Corning Tower, Room 1258
Empire State Plaza
Albany, New York 12237-0016

File copy

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 145 Huguenot Street New Rochelle, New York 10801

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

November 8, 2001

Edward A. Stolzenberg
President/CEO
Westchester Medical Center
Grasslands Reservation
Valhalla, New York 10595

Re: Incident #11390707002

Dear Mr. Stolzenberg:

The plan of correction for the July 31, 2001 survey which you submitted has been reviewed by this office and is acceptable.

Please continue to implement this plan of correction. This office reserves the right to re-survey for compliance with these code sections at any time.

If there are any questions, please contact this office at (914) 654-7011.

Sincerely,

Patrick Clemente

Patrick Clemente
Assistant Program Director
Hospital & Primary Care Services/EMS

cc: Mark Tulis, Esq.