

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

PRINTED: 01/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2008
NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467	
(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 167 SS=C	<p>483.10(g)(1) EXAMINATION OF SURVEY RESULTS</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not post the most recent Department of Health (DOH) Statement of Deficiencies (SOD), readily accessible in a place that it could be reviewed without asking for staff assistance.</p> <p>This resulted in no actual harm with potential for more than minimal harm.</p> <p>Finding is:</p> <p>On 9/22/08 at 9:10AM, during the initial tour, it was observed that the complete survey results of the most current survey of the facility was not posted at the reception area. A posting in each of the unit floors documents: "A copy of the 10/15/07 Department Of Health survey results is available at the reception desk in the lobby." On the bulletin board in the corridor off the lobby was observed the Survey Profile Summary sheets from the last survey which did not identify the actual survey deficiencies.</p>	F 167		11/23/08
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 167	Continued From page 1 On 9/22/08, at 10:30AM, the facility's receptionist was asked where the SOD from the last DOH survey could be viewed. The receptionist pulled out the 10/15/07 DOH survey results from behind the receptionist's desk. The receptionist was asked if the DOH survey results are always kept behind his desk. He said yes. An interview was conducted with the Administrator on 9/23/08, at 9:30AM. The Administrator stated that she had been unaware that the DOH survey results were not readily accessible in a place that it could be reviewed without asking for staff assistance.	F 167			
F 225 SS=D	415.3(1)(c)(1)(v) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		11/23/08	

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F 225	<p>Continued From page 2 State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility did not ensure that residents injuries of unknown origin were thoroughly investigated to rule out incidents of abuse/neglect and mistreatment for 2 of 27 residents in the sample (Residents #9 and #15).</p> <p>This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings are:</p> <ol style="list-style-type: none"> Resident #15 has diagnoses which include Dementia, and Seizure Disorder. <p>A review of the resident's current Minimum Data Set dated 7/7/08 documents that cognition for resident as "severely impaired" and requires total dependence with activities of daily living.</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>A review of the resident's nursing progress notes documented that on 6/20/08, the resident was found with an old ecchymotic area to her right breast; on 6/21/08, the ecchymotic area to the right breast was noted as black and blue and the nursing supervisor was notified; and on 7/3/08, the physician examined the ecchymotic area and determined that the resident required no treatment.</p> <p>There is no documented evidence that an investigation was conducted regarding the resident's ecchymosis of unknown origin to the right breast.</p> <p>2. Resident #9 has diagnoses which include Dementia with Psychosis and Diabetes.</p> <p>A review of the current Minimum Data Set dated 8/11/08 documents that the cognition for Resident #9 to be "severely impaired".</p> <p>A review of a nursing progress note dated 8/24/08 documents that staff had noted a bruise to the resident's left hand and that the resident was unable to say what happened. The physician examined the left hand and noted it to be an old bruise that was healing.</p> <p>There was no documented evidence that an investigation was conducted regarding the resident's ecchymosis of unknown origin to the left hand.</p> <p>A review of the facility's policy for "Incidents of Unknown Origin" indicates that all incidents regarding residents must be reported immediately to the nurse in charge. Further investigation is</p>	F 225			

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F 225	Continued From page 4 required for those incidents and /accidents that are discovered where the cause is not determinable due to the resident inability to relate. On 9/23/08 at 2:30 PM, the Assistant Director of Nursing was interviewed and stated that the unit Nursing Supervisor for the unit had recently resigned. The Assistant Director of Nursing stated that she was unable to find an Incident/Accident Reports for Residents #9 and #15 and did not know if the residents' bruises had ever been investigated to determine cause and to rule out abuse/neglect or mistreatment.	F 225		
F 323 SS=E	415.4(b)(1)(ii) 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not maintain the residents ' environment free of accidents and hazards in that resident room windows were observed to open to its full extent without restriction. The windows should have stops so they can not be opened more than 6 inches. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 323		11/23/08

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F 323	Continued From page 5 The finding is: On September 23, 2008 at approximately 1:30 pm during the annual life safety tour it was observed that the windows in the OT/PT area were not designed to prevent accidental falls when opened. These windows opened fully without any window stops to restrict the height to the required 6 inches. In an interview with the Director of Facilities on September 23, 2008 at approximately 1:50 pm he stated that the window stops would be installed immediately in order to restrict the windows to the required 6 inches.	F 323			
F 463 SS=E	CFR 415.12(h)(1) NYCRR 713-1.15(a)(7) 483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure to maintain the call bell system in a working manner. The duty station within the pantry and soiled utility room did not display a visual signal when the resident call bell was activated. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 463		11/23/08	

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F 463	Continued From page 6 The finding is: On September 23, 2008 at approximately 2:00 pm during the annual life safety tour it was observed that the facility did not ensure to maintain the nurse's call system in that no visual signal was displayed when it was activated in the pantry and soiled utility room on the following floors: 1. On the 6th floor- the nurse ' s call system did not display a visual signal in the soiled work room once the resident call bell was activated. 2. On the 4th floor- the nurse ' s call system did not display a visual signal in the pantry room when the resident call bell was activated. 3. On the 3rd floor- the nurse ' s call system did not display a visual signal in the pantry room and soiled work room when the resident call bell was activated. 4. On the 2nd floor- the nurse ' s call system did not display a visual signal in the pantry room and soiled work room when the resident call bell system was activated. In an interview with the Director of Maintenance on September 23, 2008 at approximately 2:15 pm he stated that the bulbs would be replaced immediately and periodic rounds would be made by the housekeeping staff to check to see if the bulbs are working. 415.29 NYCRR 713-2.24 (g) Electrical requirements	F 463		
F 468 SS=E	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly	F 468		11/23/08

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F 468	<p>Continued From page 7</p> <p>secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility did not ensure hand rails were continuously provided within the corridor. Breaks in the hand rail were observed in the corridor between resident rooms 615 and 616. The same was observed and noted on resident floors 4 and 5.</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>The findings are:</p> <p>On September 22, 2008 at approximately 12:10 pm during the annual life safety tour it was observed that hand rails were not continuously provided out side of resident rooms on the following floors:</p> <ol style="list-style-type: none"> 1. 6th floor- An area approximately 3 feet in length between resident rooms 615 and 616 in the corridor was not provided with hand rails. 2. 5th floor- An area approximately 3 feet in length between resident rooms 515 and 516 in the corridor was not provided with hand rails. 3. 4th floor- An area approximately 3 feet in length between resident rooms 415 and 416 in the corridor was not provided with hand rails. <p>In an interview with the Director of Maintenance on September 22, 2008 at approximately 12:30 pm he stated that this section of the corridor will be provided with handrails immediately.</p>	F 468		

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F 468	Continued From page 8	F 468		
F 514 SS=D	<p>415.29</p> <p>483.75(l)(1) CLINICAL RECORDS</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 staff interviews and record review, the facility did not ensure that the medical record was accurately documented as evidence by omissions on the medication administration records. This was evident for 1 of 3 closed records reviewed. (resident # 27)</p> <p>This resulted in no actual harm with potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #27 was an 86 years old female with diagnoses which include Alzheimer's, Dementia, Hypertension, pressure ulcers and Colitis.</p> <p>The Minimum Data Set 2.0 Assessment dated 8/21/08 documents that resident had severely impaired cognitive skills for daily decision making</p>	F 514		11/23/08

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F 514	<p>Continued From page 9 and requires total assistance with activities of daily living.</p> <p>The Physician's Orders dated 7/10/08 and 8/7/08 documented medication orders for Insulin Lantus injection, Oscal with Vitamin D, Simvastatin, Beneprotein, Prevacid Solutab, Vitamin C 500 mg/5 ml syrup, Zinc Sulfate 220 mg and treatment orders for triple antibiotic ointment and Hydrogel apply to left lateral foot, left heel and left foot dorsum daily and Gentamicin sulfate/ Optase/ and triple antibiotic apply to sacrum ulcer daily and PRN (as needed).</p> <p>The Medication Administration Records dated 7/11/08 to 8/8/08 and 8/8/08 to 8/26/08 documented multiple omissions in the administration of medications on 7/20/08, 7/24/08, 8/2/08, 8/6/08, 8/7/08, 8/8/08, 8/11/08, 8/21/08 and 8/23/08.</p> <p>The Treatment Administration Record dated 7/11/08 to 8/10/08 documented that there were omissions for pressure ulcer treatments from 8/8/08 through 8/10/08.</p> <p>On 9/24/08 at 3:30 PM, the Assistant Director of Nursing was interviewed and stated that based on standards of nursing practice, the nurse is supposed to follow physician's orders of medications and treatments. She stated that if there is no documentation, it means it was not given.</p> <p>On 9/24/08 at 3:45 PM, the Medical Director was interviewed and stated that standards of practice is for the staff to follow the doctors orders. Medications should be given as ordered and treatment should be done as ordered.</p>	F 514			

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F 514	Continued From page 10 415.22(a)(1-4)	F 514		
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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 335373	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 11/24/2008
Name of Facility BAINBRIDGE NURSING AND REHABIL	Street Address, City, State, Zip Code 3518 BAINBRIDGE AVENUE BRONX, NY 10467	

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. # NFPA 101 LSC <u>K0025</u>	Correction Completed 11/23/2008	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0033</u>	Correction Completed 11/23/2008	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0071</u>	Correction Completed 11/23/2008
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: 9/24/2008	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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ID Prefix <u>F0167</u> Reg. # <u>483.10(g)(1)</u> LSC _____	Correction Completed 11/23/2008	ID Prefix <u>F0225</u> Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</u> LSC _____	Correction Completed 11/23/2008	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 11/23/2008
ID Prefix <u>F0463</u> Reg. # <u>483.70(f)</u> LSC _____	Correction Completed 11/23/2008	ID Prefix <u>F0468</u> Reg. # <u>483.70(h)(3)</u> LSC _____	Correction Completed 11/23/2008	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 11/23/2008
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

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: 9/24/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO

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

PRINTED: 01/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335373	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2008
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NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467
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(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
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined that smoke barriers exhibited obscure penetrations and were not constructed to resist the passage of fire and smoke. NFPA 101 2000 19.3.7.3 This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The findings are: On 9/22/08 at approximately 12:00 pm the smoke barrier on the 6th floor was inspected. Gaps (2 x 6 inches) were evident at the juncture points	K 025		11/23/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467	
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K 025	Continued From page 1 where structural members of the corridor walls met the smoke barrier. Light from a flashlight positioned on one side of the smoke barrier was visible from the opposite side. These penetrations were not otherwise readily visible. The above penetration was on the room 601 side of the corridor. Similar obscure penetrations (1 x 5 inches) of the smoke barrier were found on the 6th floor near room 614 and on the 5th floor (side opposite 501). In this instance the penetration was noted above the suspended ceiling from the lavatory in the resident room. All smoke barriers shall be thoroughly inspected, particularly at the juncture points with structural members of the corridor walls to ensure that smoke barriers are intact without openings. The above inspections shall be conducted from the corridor side and from the resident rooms side of the corridor. In an interview with the Director of Facilities at the time, he indicated that these constituted original construction. He indicated that the penetrations would be closed with appropriate fire resistive construction.	K 025		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview it was	K 033		11/23/08

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NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467	
(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
K 033	<p>Continued From page 2</p> <p>determined that both exit stairs exhibited penetrations leading to other parts of the building and were not separated by fire resistive construction. NFPA 101 2000 19.3.1.1</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>The findings are:</p> <p>The top landings of the two exit stairs were provided with suspended ceilings that obscured inspection of the areas above these ceilings and determination as to whether the exits were properly separated by fire resistive construction. The following examples were noted on 9/22/08 during morning environmental rounds (9:30-12:30).</p> <p>1) A small, intervening anti-room was situated between the top level of the East exit stairs and the boiler room. The upper walls of this anti-room (above the suspended ceiling) exhibited penetrations around pipes and bar joists going through the walls. The penetrations from this anti-room into both the exit stairs and the boiler room constituted a lack of compartmentation between the boiler room and the exit stairs.</p> <p>2) The West exit stair is situated adjacent to the rooftop elevator machine room. A penetration 2 inches in diameter was noted in a common wall between these two areas. This penetration led to the adjacent exit stair above the level of the suspended ceiling.</p> <p>3) Two small penetrations were noted in the upper wall of the 6th floor West exit stair. These</p>	K 033		

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NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467	
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K 033	Continued From page 3 penetrations were around wires passing through the corridor wall.	K 033		
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the laundry chute was in disrepair. The laundry chute discharge room	K 071		11/23/08

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NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467	
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K 071	<p>Continued From page 4</p> <p>also exhibited wall penetrations leading to the exit corridor and the adjacent main electrical room. NFPA 101 2000 19.5.4</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>The findings are:</p> <p>On 9/23/08 at approximately 10:50 am the laundry discharge room was inspected. It was noted that the laundry chute exhibited separated sheet metal sections with gaps evident into the chute itself. Laundry bags coming down the chute were directly visible. The compartmentation of the chute was compromised and this no longer constituted a fire rated assembly.</p> <p>Upper walls of the laundry discharge room exhibited penetrations and missing sheetrock. In particular, missing sheetrock was visible behind the laundry chute and this was a common wall with the main electrical room. Several penetrations were also noted in the corridor wall to both the electrical room and the laundry discharge room. The involved areas shall be repaired with appropriate fire resistive construction. In an interview with the Director of Facilities, he said that he was unaware that the laundry chute was in disrepair.</p>	K 071		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335373	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2008
NAME OF PROVIDER OR SUPPLIER BAINBRIDGE NURSING AND REHABIL		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 BAINBRIDGE AVENUE BRONX, NY 10467		
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I560 SS=E	<p>713-1 Standards of Construction for New Existing NH</p> <p>This Regulation is not met as evidenced by: The facility must ensure doors, sidelights, borrowed lights, and windows in which the glazing extends down to within 18 inches of the floor, thereby creating possibility of accidental breakage by pedestrian traffic, shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken.</p> <p>This standard is not met as evidenced by:</p> <p>Based on observation and staff interview it was determined that the facility did not ensure that approximately 18 individual glass panels in the recreation office and smoke room doors were tempered in order to prevent accidental breakage.</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>The findings are:</p> <p>On September 23, 2008 at approximately 11:00 pm during the annual life safety tour it was observed that the smoking room and recreation office room doors had approximately 18 individual glass panels which were not tempered in order to prevent accidental breakage by pedestrian traffic.</p> <p>1. On the 1st floor, the recreation office room door has approximately 18 individual glass panels which are approximately 12 inches from the floor and is not tempered. The glass panels have to be tempered in order to prevent accidental</p>	I560		11/23/08

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: 335373	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2008
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I560	Continued From page 1 breakage. 2. On the 1st floor, the smoking room door has approximately 18 individual glass panels that are approximately 12 inches from the ground and is not tempered. The glass panels have to be tempered in order to prevent accidental breakage. In an interview with the Director of Maintenance on September 23, 3008 at approximately 11:30 pm he stated that the glass panels are not tempered and he would replace the bottom 3 panels with tempered glass. NYCRR 713-1.15 (9) Details and Finishes	I560			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 2	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 11/24/2008
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Name of Facility BAINBRIDGE NURSING AND REHABIL	Street Address, City, State, Zip Code 3518 BAINBRIDGE AVENUE BRONX, NY 10467
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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>1560</u>	Correction Completed 11/23/2008	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>713-1</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: 9/24/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		