

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 253<br>SS=B  | <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>483.15 (h)(2) Sanitary includes but not limited to, preventing the spread of disease causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes toothbrushes, dentures, denture cups, glasses and water pitchers, emesis basins, hair brushes and combs, bed pans, urinals, feeding tubes, leg bags and catheter bags, pads and positioning devices.</p> <p>Based on observation and interview it was determined that the facility did not ensure that nursing supplies were stored in a sanitary manner. Nursing supplies were observed on the floor under the shelves on 2 out of 5 resident floors.</p> <p>This resulted in no actual harm with the potential for minimum harm.</p> <p>During the annual life safety survey, a tour was conducted on June 3, 2008 at approximately 12:30 pm and the following was observed and noted:</p> <p>1. On the 4th floor in the nursing supply closet 1 cotton swab, 2 gauze, 2 bibs, 2 bottles of total bath skin cleanser, 1 box of cigarettes, 1 bottle of perigene denna rite body wash, pieces of plastic and 1 connection for the trach were all observed stored on the floor underneath the shelves.</p> | F 253   |   | 6/20/08   |
| 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.

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 253  | Continued From page 1<br>2. On the 3rd floor in the nursing supply closet 1 bottle of perigene dennarite body wash, 1 bottle of perigene anti perspirant and pieces of plastic were observed stored underneath the shelves.<br><br>In an interview with the director of housekeeping conducted at 1:45 pm, he stated that housekeeping should be cleaning under the shelves but it was apparent based on observation that they did not. He also stated that he would inform the porter from each floor to make sure they clean under the shelves.   | F 253   |   |   |
| F 281<br>SS=D  | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility did not ensure that standards of practice were followed as evidenced by the licensed nurses not reviewing the bowel movement record of a resident with a history of constipation. This was evident for 1 of 30 sampled residents. (Resident #15).<br><br>This resulted in no actual harm with the potential for more than minimal harm.<br><br>The finding is:<br><br>Resident #15 is a 93 year old male with diagnoses including Alzheimer/Dementia, Hypertension, and a history of constipation.<br><br>The Minimum Data Set (MDS) Version 2.0 documents: Short term and Long term memory | F 281   |   | 6/30/08   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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  | <p>Continued From page 2</p> <p>loss, Bladder Incontinent, Bowel Continent, and Extensive assistance requiring 1 person assist for toileting.</p> <p>The Comprehensive Care Plan (CCP) dated 2/01/08 documented that the resident is on a toileting schedule every 2-4 hours because of a history of constipation and urinary incontinence.</p> <p>The physicians' orders dated 11/21/07 to 5/22/08 documented Colace liquid 30 ml (milliliter) to be given once daily at hour of sleep.</p> <p>The Certified Nursing Assistant's (CNA) bowel movement record dated 3/08 documented that the resident had no bowel movements on 3/1/08 through 3/6/08, and 3/11/08 through 3/14/08.</p> <p>The nursing notes dated 3/1/08 to 3/14/08 did not document any evidence that the resident did not have bowel movements during this period.</p> <p>On 6/3/08 at 10:00 AM, the CNA assigned to the day shift was interviewed and stated that the resident had no bowel movement on her shift so that a zero was placed on the bowel movement record. However, the CNA added that the resident self toilets. The CNA stated that she did not report her documentation of no bowel movement to the charge nurse.</p> <p>On 6/3/08 at 10:25 AM, the Registered Nurse (RN)/ Nursing Supervisor for the day shift was interviewed and she reviewed the nursing notes from 3/1/08 to 3/14/08, and stated that the CNAs did not report that the resident did not have bowel movements for three consecutive days. She further stated that the resident has not exhibited signs of distress, and had no complaints of</p> | F 281   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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  | Continued From page 3<br>abdominal discomfort. She stated that resident has a history of constipation, and was prescribed Colace. The RN did not have an answer as to why the bowel movement record was not reviewed by the licensed nursing staff.<br><br>On 6/4/08 Director of Nursing (DON) reviewed the Facility ' s policy on Bowel Movement Protocol and stated that if the resident does not have a bowel movement in three consecutive days or nine shifts, the CNA must notify the charge nurse before the end of the shift. She stated that if this was not done in this case it was a deviation from the policy.<br><br>The DON also reviewed the facility ' s policy on routine resident care. She stated that it is the responsibility of the charge nurse to routinely review the chart of the resident, and this includes the CNA accountability records. The bowel movement record should be reviewed by the nurse on a routine basis. The nurse should record in the nursing notes when there are no record of bowel movements on three consecutive days, or nine shifts. The nurse should then note the appropriate interventions. She stated that if this was not done then it is a deviation from the policy and the standards of nursing practice. | F 281   |   |   |
| F 282<br>SS=D  | 415.11(c)(3)(i)<br>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  | F 282   |   | 6/23/08   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 282  | <p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record reviews and staff interviews, the facility did not ensure that physician's order for chewing a medication was implemented. This was evident for 1 of 30 sampled residents. (Resident #21)</p> <p>This resulted in no actual harm with potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #21 is a 56 year old male with diagnoses which include convulsions, Unspecified mental retardation, and pressure ulcer.</p> <p>The Minimum Data Set (MDS) Version 2.0 dated 2/24/08 documented that the resident has modified independence for cognitive skills for daily decision making.</p> <p>On 6/4/08 at 9:20 AM, during the medication pass observation on the 6th floor, the Licensed Practical Nurse (LPN) was observed administering medications to Resident #21. The LPN was observed instructing resident to swallow his medications including Carbazapine.</p> <p>The Physician's Order dated 5/808 documented "Carbazapine 100 mg (milligrams) Chewable Tab (tablets) Chew 3 tablets by oral route 4 times a day."</p> <p>On 6/4/08 at 10:59 AM, the LPN was interviewed and stated "I usually instruct and encourage him to chew the carbazepine but I did not do that today. I'm sorry, I made a mistake."</p> | F 282   |   |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 282  | Continued From page 5<br>On 6/4/08 at 11:10 AM, the Registered Nurse (RN)/Nurse Manager was interviewed and stated that if there is an order for the medication to be chewed, the medication nurse must tell the resident what the medication is, what it is for, and to chew the tablet as ordered. The RN/Nurse Manager stated that she will reinforce and do an inservice with the staff.   | F 282   |   |   |
| F 371<br>SS=E  | 415.11 (c)(3)(ii)<br>483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon interview and observation it was determined that the facility did not ensure that food was stored properly under sanitary conditions. This was evidenced by the storing of raw chicken over ready to eat food in the walk-in meat refrigerator. The dairy walk-in refrigerator contained a white substance under the wheels of the moveable shelves and in the produce walk-in refrigerator a white substance was observed under the wheels of the moveable shelves. Onion peels, crumbs of food and a piece of celery were also observed in the produce box. Dented cans were observed mixed in with the good cans within the store room area as well as on the shelves in the kitchen.<br><br>This resulted in no actual harm with the potential for more than minimal harm that is not immediate | F 371   |   | 6/10/08   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 371  | <p>Continued From page 6 jeopardy.</p> <p>The findings were:</p> <p>During a kitchen tour on June 3, 2008 between 9:00 am and 11:00 am the following was observed and noted:</p> <ol style="list-style-type: none"> <li>In the meat walk-in refrigerator uncooked chicken was observed stored over 1 turkey roll which posed a contamination threat from dripage.</li> <li>In the dairy walk-in refrigerator a white substance was observed on the floor under the wheels of each moveable shelf.</li> <li>In the produce walk-in refrigerator a white substance was observed under the wheels of each moveable shelf. In addition onion peels, a piece of celery and crumbs of food were also observed on the floor and shelves.</li> </ol> <p>In an interview with the Dietary Supervisor at approximately 10:00 am, she stated that she thinks the white substance was from condensation and would inform housekeeping to clean it up immediately.</p> <ol style="list-style-type: none"> <li>In the dietary store room at approximately 11:05 am the following dented cans were observed stored together with undamaged cans in the store room as well as on the kitchen shelves. The items are as follows:<br/>-3 6 lb. 3 oz. cans of whole potatoes<br/>-3 7 lb. 3 oz. cans of tomato ketchup<br/>-1 6 lb. 8 oz. can of diced beats<br/>-1 6 lb. 9 oz. can of henry ' s best marinara sauce</li> </ol> <p>The Dietary Supervisor stated that the dented</p> | F 371   |   |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 371  | Continued From page 7<br>cans are usually separated in the store room in the basement before they are transported to the kitchen. The dented cans are kept in a gray bin inside the kitchen storage room but when checked the bin did not contain any dented cans.<br><br>NYCRR 415.14(h)<br>State Sanitary Code, Subpart 14-1<br>14-1.40(a)<br>14-1.43(c)<br>14-1.110(d)<br>14-1.170  | F 371   |   |   |
| F 498<br>SS=D  | 483.75(f) PROFICIENCY OF NURSE AIDES<br><br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews, the facility did not ensure that nurses aides are able to demonstrate competency in weighting residents using the Hoyer lift (Resident # 2), and reporting to licensed nurses changes in the resident condition (Resident #15). This was evident for 2 of 30 Sampled residents. (Resident #s 2 and 15) as evidenced by:<br><br>This resulted in no actual harm with potential for more than minimal harm.<br><br>The findings are:<br><br>1) Resident #2 is a 41 year old male with diagnoses which include Paraplegia, Depression | F 498   |   | 6/23/08   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 498  | <p>Continued From page 8 and Schizophrenia.</p> <p>The Minimum Data Set (MDS) Version 2.0 dated 4/7/08 documented that the resident has modified independence for cognitive skills and requires total dependence of 2 persons assist for transfers.</p> <p>The Nurse's Note dated 2/1/08 documented "Resident for monthly weight today-while being weighed on lift scale-equipment broke resident sustained fall to buttocks-resident returned to bed. MD immediately notified and ordered transfer to hospital for evaluation."</p> <p>The Accident/Incident Report dated 2/1/08 documented "Statement from Certified Nurse Aide (CNA) Resident was on Hoyer Lift for weight while lift was in a high position, lift broke and resident fell to the floor."</p> <p>On 6/5/08 at 12:45 PM, the CNA who assisted in weighing the resident on 2/1/08, was interviewed and stated that she remembered assisting the assigned CNA to the resident. The CNA stated "I was holding the Hoyer lift and the other CNA was on the other side. We put him on the green canvas then to Hoyer Lift. I lifted the Hoyer Lift with the resident up. Then I moved the Hoyer Lift with the resident away from the bed so nothing is touching the bed. It was fast. Hoyer Lift broke and resident fell to the floor."</p> <p>On 6/5/08 at 12:50 PM, the Registered Nurse (RN)/Nurse Manager was interviewed and stated that she did not witness the actual fall. The RN stated "They were weighing him when the tip (hook) that holds the mesh gave way. I checked the resident and notified the physician. Resident</p> | F 498   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 498  | <p>Continued From page 9</p> <p>was transferred to the hospital. He is paraplegic and he did not have pain." The RN did not respond when asked what is the proper way of weighing the resident using a Hoyer Lift.</p> <p>Review of the facility's protocol on weighing a patient with the use of a Hoyer Lift documents: "It is necessary to raise patient only enough so that frame does not come in contact with the mattress, Pumping lift handle will raise frame off bed, and to lower patient, open valve slowly. The protocol did not instruct staff to move Hoyer Lift with the resident away from the bed.</p> <p>2) Resident #15 is a 93 year old male with the following diagnoses: Alzheimer/Dementia, Hypertension, and a history of constipation.</p> <p>The Minimum Data Set 2.0 assessment (MDS) documented that the resident has short and long term memory problems, bladder incontinence, bowel continent and requires extensive assistance of 1 person for toileting.</p> <p>The Comprehensive Care Plan dated 2/01/08 documented that the resident is on a toileting schedule every 2-4 hours because of a history of constipation and urinary incontinence.</p> <p>The physician order dated 11/21/07 to 5/22/08 documented Colace liquid 30 ml (milliliters) to be given once daily at hour of sleep.</p> <p>The Certified Nursing Assistant (CNA) bowel movement record documented that the resident did not have bowel movements from 3/1/08 to 3/6/08, and 3/11/08 to 3/14/08.</p> <p>On 6/3/08 at 10:00 a.m., the CNA assigned to the</p> | F 498   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 498  | <p>Continued From page 10</p> <p>day shift was interviewed and stated that the resident is on a toileting program, but also self toilets. She added that when she does not observe a bowel movement at the time she documents on the bowel record, she records that there was no bowel movement. However, she claims that the resident is alert and oriented enough that the CNA can ask him if he has had a bowel movement. According to her recollection the resident has stated that he has had regular bowel movements. She stated that the resident has not complained of abdominal discomfort or exhibited symptoms of distress. She did not report her documentation of no bowel movement to the charge nurse.</p> <p>On 6/4/08 Director of Nursing was interviewed and stated that the facility's policy is that if the resident does not have a bowel movement in three consecutive days or nine shifts, the CNA must notify the nurse before the end of the shift.</p> <p>415.26(c)(1)(iv)</p> | F 498   |   |                      |   |

**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><br>335506 | <b>(Y2) Multiple Construction</b><br>A. Building<br>B. Wing                           | <b>(Y3) Date of Revisit</b><br>7/14/2008 |
| <b>Name of Facility</b><br>BRONX CENTER FOR REHAB HEALTH                 | <b>Street Address, City, State, Zip Code</b><br>1010 UNDERHILL AVE<br>BRONX, NY 10472 |  |

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>F0253</u><br>Reg. # <u>483.15(h)(2)</u><br>LSC _____ | Correction<br>Completed<br><b>06/20/2008</b> | ID Prefix <u>F0281</u><br>Reg. # <u>483.20(k)(3)(i)</u><br>LSC _____ | Correction<br>Completed<br><b>06/30/2008</b> | ID Prefix <u>F0282</u><br>Reg. # <u>483.20(k)(3)(ii)</u><br>LSC _____ | Correction<br>Completed<br><b>06/23/2008</b> |
| ID Prefix <u>F0371</u><br>Reg. # <u>483.35(i)(2)</u><br>LSC _____ | Correction<br>Completed<br><b>06/10/2008</b> | ID Prefix <u>F0498</u><br>Reg. # <u>483.75(f)</u><br>LSC _____       | Correction<br>Completed<br><b>06/23/2008</b> | ID Prefix _____<br>Reg. # _____<br>LSC _____                          | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                      | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                         | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                          | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                      | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                         | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                          | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                      | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                         | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                          | Correction<br>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:<br>6/5/2008 | Check for any Uncorrected Deficiencies. Was a Summary of<br>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  |     |    |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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                                |
| K 000  | INITIAL COMMENTS   | K 000   |   |   |
| K 020<br>SS=F  | <p>42 CFR 483.70(a)(1):<br/>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>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview it was determined that the building has unprotected vertical openings. This was evident in exit stairs and an interstitial void that were not separated by fire resistive construction and could result in the vertical spread of fire and/or smoke. NFPA 101 2000 19.3.1.1, 8.2.5</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>1) During the Life safety survey rounds on 6/3-4/08, it was observed that fire compartmentation was lacking in many parts of the two stair enclosures. Multiple examples of a lack of fire compartmentation, for both exit stairs, were noted as indicated below;</p> <ul style="list-style-type: none"> <li>- Multiple gaps were noted in the walls forming the exit stair landings where the top wall</li> </ul> | K 020   |   |   |

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.

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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                                |
| K 020  | Continued From page 1<br>plate met the corrugated deck above. These penetrations need to be "safed off" with appropriate fire rated material.<br>- 6/3/08 3:15 pm - 4th floor exit stair A.<br>- 6/4/08 10:30 am - basement level stair<br>B<br>- 6/4/08 10:45 am - 2nd floor stair A<br>- 6/4/08 11:15 am - 2nd floor stair B<br>- On 6/4/08 at approximately 9:30 am, it was noted that the basement level of exit stair A (above the suspended ceiling) exhibited a partial wall omission and was not separated from the adjacent janitor's closet (4 foot x 1 1/2 foot in size). It was also noted that a HVAC duct from the adjacent mechanical room (above suspended ceiling) penetrated one wall of this exit stair, took a turn and then penetrated the wall of this exit stair into the corridor. Neither wall penetration of the exit stair by this duct was provided with a fire damper. HVAC ducts shall not pass through an exit stairs.<br>- Proper compartmentation of the exit stair landings was difficult to determine at some locations due to the presence of structural members that limited visibility. Use of a flashlight revealed that light from the corridor was visible from within the stairs (4th floor stair A on 6/3/08 at 3:15 pm). On 6/4/08 at 11:15 am a gap 3-4 inches high was noted above a structural beam that did not meet the corrugated deck above. This gap above the level of the suspended ceiling led to the corridor. In an interview with the Director of Maintenance at the time indicated that these issues were all original construction.<br><br>2) - On 6/3/08 at approximately 2:10 pm the tub room on the 4th floor was inspected. It was noted that an interstitial void existed that was accessed via an inspection/service door. Holes were noted | K 020   |   |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 |   |
| K 020  | Continued From page 2<br>in the floor within this void leading down to the 3rd floor below and in the ceiling leading to the 5th floor above of this interstitial void. Inspection of this interstitial void on the 6th floor (6/3/08 at 12:30 pm) revealed similar penetrations of the floor/ceiling slab . The walls within this void exhibited exposed wall studding, were not faced with sheetrock and did not appear to constitute a fire rated assembly. The penetration of the floor/ceiling assembly within this interstitial void constituted an unprotected vertical opening.<br>- The above indicated void also contained a vertical HVAC riser. The riser was not within a fire rated shaft (metal ducting visible). Horizontal oriented fire dampers were not provided where this riser penetrated the floor/ceiling slab and ducts emerging from this riser were not provided with fire dampers at the air registers. The inspection/service access door to this void was of sheet metal construction, was not labeled as a fire rated door assembly and did not appear to be a fire rated assembly. It was difficult to determine if the above construction was compliant. However, there appeared to be an inconsistency in compartmentation separating the occupied space of the building from this void and the vertical HVAC riser. An architectural evaluation is warranted. Interview at the time with the Director of Maintenance indicated that this was new construction which was done approximately two years ago. Review of blueprints after the exit interview with the Administrator and the Director of Maintenance failed to clarify this matter. | K 020   |   |                      |   |
| K 025<br>SS=E  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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  | K 025   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 |   |
| K 025  | <p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview it was determined that the smoke barriers were not constructed to resist the passage of smoke. NFPA 101 2000 19.3.7.3, 8.3</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 6/3/08 at approximately 3 pm the smoke barrier on the 4th floor was examined. It was noted in rooms 403 and 404, that the top plate of the barrier wall met the corrugated deck above. Multiple gaps were apparent where the corrugated flutes of the decking did not meet flush with the top of the barrier wall. Similarly, the smoke barrier wall in room 217 exhibited multiple gaps where the wall met the corrugated deck above (6/4/08 at 11 am). The areas involved were above the level of the suspended ceiling. The multiple gaps need to be "safed off" with appropriate fire resistive material. All smoke barriers shall be examined and addressed as necessary. In an interview with the Director of Maintenance at the time, he indicated that this</p> | K 025   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 |   |
| K 025  | Continued From page 4 was original construction.   | K 025   |   |                      |   |
| K 029<br>SS=D  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined that hazardous areas were not separated by construction designed to resist the passage of smoke. NFPA 101 2000 19.3.2.1<br><br>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.<br><br>The findings are:<br><br>On 6/4/08 at approximately 9:50 am, the generator/electrical room was inspected. It was noted that the corridor wall of this room (above the door) exhibited penetrations above the level of the suspended ceiling. In an interview with the Director of Maintenance he indicated that this was original construction. | K 029   |   |                      |   |
| K 056<br>SS=D  | NFPA 101 LIFE SAFETY CODE STANDARD   | K 056   |   |                      |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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                                |
| K 056  | <p>Continued From page 5</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview it was determined that some areas of this fully sprinklered building was missing fire sprinkler heads. NFPA 101 2000 19.3.5</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>On 6/3/08 at approximately 9:10 am, the kitchen was inspected. At this time it was noted that three walk in refrigerators (meat, dairy and produce) were without sprinkler heads. Plumbing lines were present at the ceiling within the walk in refrigerators and were capped. It appeared that the heads had been removed or that they had never been installed. In an interview with the Director of Maintenance at the time, he indicated that he was uncertain why they were missing, but thought that perhaps a concern for freezing may have led to their being removed.</p> | K 056   |   |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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                                |
| K 062<br>SS=E  | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview it was determined that the facility did not maintain the automatic sprinkler system from accumulating dust and lint. This was evident by the dusty and painted sprinkler heads observed on 4 out of 7 floors in the facility.</p> <p>This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>On June 3-4, 2008 between 12:00 pm and 3:00 pm during the annual life safety survey the following was observed and noted:</p> <ol style="list-style-type: none"> <li>1. Sprinkler heads on the 4th floor in the dining room and pantry room areas were observed to have dust and paint on them.</li> <li>2. Sprinkler heads on the 3rd floor by the nurses ' station and day room were observed coated with dust.</li> <li>3. 4 Sprinkler heads on the 2nd floor in the dining room area were observed to have dust on them. 3 Sprinkler heads in the north and south corridors were also observed to be dusty.</li> <li>4. 2 Sprinkler heads on the 1st floor dinning room area were observed to be coated with dust.</li> <li>5. 4 sprinkler heads located in the basement area in the laundry room were observed coated</li> </ol> | K 062   |   |   |

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

PRINTED: 09/04/2008  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>335506</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/05/2008</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRONX CENTER FOR REHAB HEALTH</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 UNDERHILL AVE<br/>BRONX, NY 10472</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 |   |
| K 062  | Continued From page 7 with lint.<br><br>In an interview with the director of housekeeping between 12:00 pm and 3 pm, he stated that the sprinkler heads will be cleaned immediately.<br><br>711.2(A) | K 062   |   |                      |   |

**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><br>335506 | <b>(Y2) Multiple Construction</b><br>A. Building <b>01 - MAIN BUILDING 01</b><br>B. Wing | <b>(Y3) Date of Revisit</b><br>8/8/2008 |
| <b>Name of Facility</b><br>BRONX CENTER FOR REHAB HEALTH                 | <b>Street Address, City, State, Zip Code</b><br>1010 UNDERHILL AVE<br>BRONX, NY 10472    |   |

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 _____<br>Reg. # <b>NFPA 101</b><br>LSC <u>K0020</u> | Correction<br>Completed<br><b>07/18/2008</b> | ID Prefix _____<br>Reg. # <b>NFPA 101</b><br>LSC <u>K0025</u> | Correction<br>Completed<br><b>06/20/2008</b> | ID Prefix _____<br>Reg. # <b>NFPA 101</b><br>LSC <u>K0029</u> | Correction<br>Completed<br><b>06/20/2008</b> |
| ID Prefix _____<br>Reg. # <b>NFPA 101</b><br>LSC <u>K0056</u> | Correction<br>Completed<br><b>07/01/2008</b> | ID Prefix _____<br>Reg. # <b>NFPA 101</b><br>LSC <u>K0062</u> | Correction<br>Completed<br><b>06/20/2008</b> | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                  | Correction<br>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:<br>6/5/2008 | Check for any Uncorrected Deficiencies. Was a Summary of<br>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  |     |    |