

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  07/23/2025
NAME OF PROVIDER OR SUPPLIER  Bainbridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3518 Bainbridge Avenue Bronx, NY 10467	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews during the Recertification survey conducted from 07/16/2025 to 07/23/2025, the facility failed to ensure that residents' comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment and as needed. This was evident for 1 (Resident #43) of 3 residents reviewed for Dental. Specifically, Resident #43's the Comprehensive Care Plan for oral/dental conditions was not reviewed and revised quarterly after each assessment. The findings include: The facility policy and procedure titled Comprehensive Care Plan with a revised date of 03/2025 documented that comprehensive care plans will be reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments. Resident #43 was admitted to the facility with diagnoses of Diabetes Mellitus, Anemia, and Heart Failure. The Quarterly Minimum Data Set, dated [DATE] and 04/18/2025 documented Resident # 43 was cognitively intact and had no dental issues documented. During observation on 07/16/2025 at 11:21 AM, Resident # 43 was observed with cracked teeth. Resident #43 stated they do not have mouth pain at this time. A comprehensive care plan for oral/dental conditions as evidenced by broken natural teeth was initiated on 08/07/2023. The facility interventions include inspecting mouth for any abscess, sores, or sign of infection; and to monitor food intake. The care plan was last reviewed on 07/09/2024; the care plan notes documented resident remained free from any sign and symptom of oral/dental problems, will continue plan of care for 90 days. A nursing progress note dated 01/13/2025 documented by the Former Registered Nurse Registered Nurse # 6 was called to assess Resident # 43 for tooth falling out, according to resident tooth fell out. Resident # 43 complained of no pain will continue to monitor resident dental appointment was attempted to be made but no dental appointment was secured I will call again documented. There was no documented evidence that the comprehensive care plan for oral/dental condition was reviewed and revised after each quarterly review assessments on 01/08/2025 and 04/09/2025. During an interview on 07/18/2025 at 3:14 PM, Registered Nurse #4, who was the Unit Manager, stated they do not check care plans for the residents, and they still have yet to learn how to look for and revise the resident care plans. During an interview on 07/18/2025 at 3:50 PM, the Director of Nursing stated that care plans should be completed on resident's admission, readmission, quarterly, when there is significant change, and episodic changes in a resident's clinical condition. The Director of Nursing stated that Resident # 43's dental care plan should have been reinitiated when the resident was readmitted and should have been updated. 10 NYCRR 415.11(c)(2) (i-iii)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, record review, and interviews during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility did not ensure medications and biologicals were stored in accordance with currently accepted professional principles. This was evident for 1 (5th floor) of 5 units observed. Specifically, during observation on the 5th Floor, a box filled with medications labeled with residents' names were found stored under the table at the nurse's station. These medications were not secured and were accessible to unlicensed staff and residents. The findings include: The facility policy titled Proper Storage and Return of Medications with a revised date of 05/02/2025 documented the medications must be secured, temperature controlled, and accessible only to authorized personnel. All medications and other drugs, including treatment items, shall be stored in a locked cabinet inaccessible to residents and visitors. During observation on 07/18/2025 between 12:45 PM to 1:36 PM, a cardboard box filled with multiple medications labeled Return was observed under the table in the nurses' station. The nurse's station was an open area with a walk in entry. A resident was observed wandering by the nurses' station. The contents of the cardboard box was examined with Registered Nurse #5, who was the Unit Manager, and the following medications were observed, to name a few: 6 tablets of sulfamethoxazole and trimethoprim, 29 tablets of memantine 10 milligrams, 2 tablets of metformin 500 milligrams, 6 tablets of quetiapine 25 milligram, 30 tablets of memantine 10 milligrams, 2 tablets of metformin 500 milligrams, 20 tablets of ketorolac tromethamine 10 grams, 22 tablets of mirtazapine 15 milligrams, a bottle of atorvastatin calcium 80 mg bottle, 28 tablets of mirtazapine 15 mg, 30 tablets loratadine 10 milligrams. During an interview on 07/18/2025 at 4:46 PM, Licensed Practical Nurse #3 stated the medications were supposed to be returned to the medication room for storage. They stated medication should be kept in the medication room for resident safety. During an interview on 07/18/2025 at 1:37 PM, Registered Nurse #4 stated those medications in the box should have been in some place secured for safety of the resident since they have residents who are confused and can pick up and swallow those medications. They stated the medications are for return to the pharmacy and it is the night shift nurse's responsibility to return the medications. During an interview on 07/18/2025 at 2:31 PM, Registered Nurse #5, who was the Unit Manager, stated they did not notice the box filled with medications stored at the nurse's station this morning. They stated those medications should be stored in the medication room and should not be out in the open and not accessible to non-healthcare staff and residents. During an interview on 07/18/2025 at 3:55 PM, the Director of Nursing stated the box filled with medications that were found in the nursing station are medications for return to the pharmacy. They stated these medications were scanned by the night shift nurse and should have been put back in the medication room. The Director of Nursing stated all medications must be secured for safety as they have residents who wander. 10 NYCRR 415.18(e)(1-4)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, record review, and interviews during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility did not ensure that all potentially hazardous foods were stored, prepared, distributed, and served in accordance with professional standards of food safety. This was evident for 1 (Unit 1) of 5 units observed. Specifically, the dairy refrigerator in Unit 1 was observed to be above 40 F and the items inside of it, including multiple cartons of milk, sandwiches, and cheese, were not immediately disposed of. The findings include: The facility policy titled Food Storage-Potentially Hazardous Food which was last revised on 05/01/2025 documented that it is the facility's policy to ensure the safe storage of potentially hazardous foods to prevent foodborne illnesses and maintain a clean, safe, and sanitary storage area for both food and non-food items. Refrigerators must maintain food at 41 F or below. Potentially hazardous foods, which includes dairy products, are foods that require strict temperature control to prevent the growth of harmful bacteria. For items requiring cold storage such as dairy/eggs, the recommended temperatures are 32-40 F. Any potentially hazardous foods found outside of safe temperature ranges must be discarded immediately. The Main Kitchen Refrigerator/Freezer Temperature Sheets for Unit #1 documented that the minimum acceptable temperature for the refrigerator was 40 F. It also documented that on 07/16/2025, the refrigerator was not working. On 07/16/2025 at 9:11 AM, the dairy refrigerator in Unit 1 was observed to be 45 F. The dairy refrigerator contained multiple items including crates of individual milk cartons, peanut butter sandwiches, cheese sandwiches, and individual cream cheese portions. The Food Service Director was interviewed and stated that on the evening of 07/15/2025, they observed the dairy refrigerator to be above 40 F and contacted a technician to repair it. On 07/16/2025 at 11:54 AM, a milk carton was removed from the dairy refrigerator and the temperature was tested to be at 47.6 F. The Food Service Director was interviewed and stated that the milk and other items in the refrigerator remained in the refrigerator and would not be disposed of despite it being broken because they did not believe that the refrigerator's temperature had been out of range for over two hours. They further stated that milk cartons from the broken dairy refrigerator had been served for lunch. On 07/16/2025 at 02:00 PM, the dairy refrigerator was observed to be 56 F. The Food Service Director stated that they were going to move the items in the dairy refrigerator to a different refrigerator and was then observed removing items from the dairy refrigerator with the assistance of a dietary aide. On 07/23/2025 at 10:54 AM, the Food Service Director was interviewed and stated that the dairy refrigerator was repaired on 07/18/2025. They stated that while the refrigerator was broken, the items inside of it were transferred to a different refrigerator and served to residents from that refrigerator. The milk and other potentially hazardous food items that had been inside of the broken refrigerator had not been disposed of because the Food Service Director did not believe they had been exposed to unsafe temperatures for a prolonged period of time. On 07/23/2025 at 11:32 AM, the Administrator was interviewed and stated that the Food Service Director made them aware of a problem with the dairy refrigerator's temperature. The Administrator stated that they were unsure if there had been a problem with the refrigerator's cooling ability, or if the problem was with the temperature gauge reading incorrectly. The Administrator stated that they were unaware that the milk in the refrigerator had been tested to be above 40 F. They also stated that they were unsure of whether the items in the dairy refrigerator had been immediately disposed of after the temperature was found to be out of range. 10 NYCRR 415.14(h)</p>		

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<p>F 0847</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility did not ensure the Binding Arbitration Agreement granted the residents and/or their designated representatives the right to rescind the agreement within 30 calendar days of signing it. This was evident for 3 (Resident # 146, #161, and #165) of 38 total sampled residents. Specifically, the Binding Arbitration Agreement signed by Residents #146, #161, and #165 did not grant the residents and/or their designated representatives 30 calendar days to rescind the agreement. The findings include: The facility policy titled Arbitration Agreements which was effective on 10/17/2024 and last reviewed 10/18/2024 documented that the arbitration agreement shall explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it. 1. Resident #146 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment dated [DATE] documented Resident #146's cognition as intact. The resident signed a Binding Arbitration Agreement with the facility on 07/12/2024. 2. Resident #161 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment dated [DATE] documented Resident #161's cognition as moderately impaired. Resident #161's designated representative signed a Binding Arbitration Agreement with the facility on 04/23/2024. 3) Resident #165 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment dated [DATE] documented Resident #161's cognition as intact. The resident signed a Binding Arbitration Agreement with the facility on 05/30/2024. Upon review of the signed Binding Arbitration Agreements for Residents #146, #161, and #165, it was noted that there had been no documented evidence that the facility provided the residents and/or their designated representatives 30 calendar days to rescind the agreements. On 07/22/2025 at 2:06 PM, the Assistant Director for Admissions, who was responsible for the binding arbitration agreements, was interviewed and stated that they explained the admission and binding arbitration agreements to the residents and/or their designated representative on admission. They stated most of the residents chose not to sign the arbitration agreement. They stated for those residents who signed, they have thirty days to rescind their signature. They stated their policy states that the residents have thirty days to rescind the agreement, but it is not in the signed arbitration agreement. On 07/22/2025 at 2:15 PM, the Director of Operations was interviewed and stated that the residents have thirty days to rescind the arbitration agreement. They stated the signed arbitration agreement before October 2024 did not include the thirty days to rescind the agreement. The Director of Operations stated they updated their arbitration agreement in October 2024 to include thirty days to revoke the agreement. On 07/22/2025 at 2:25 PM, the Administrator was interviewed and stated that the arbitration agreement states that they can rescind their signatures. They stated they revised the arbitration policy last year and that the time frame was included in the new arbitration agreement. 10 NYCRR 415.30</p>		