STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335557	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rebekah Rehab and Extended Care Center	1072 Havemeyer Avenue Bronx, NY 10462

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an Abbreviated Survey (Incident# 641690 and Incident # 641669), the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in three (3) out of nine (9) residents (Resident #7, #8, and #9) sampled. Specifically, 1) the facility Accident/Incident Report dated 03/01/2025 documented that Resident #7's family member reported to Licensed Practical Nurse on 03/01/2025 at 5:00 PM that two (2) Certified Nursing Assistants who were roughed with Resident #2 early in the morning. Registered Nurse Supervisor #2 interviewed Resident #7 on 03/01/2025 and the resident reported that Certified Nursing Assistant #2 held them by their neck and another (unidentified) Certified Nursing Assistant pulled their feet. The facility completed their investigation which was unsubstantiated. However, the facility did not submit the five (5) day investigation findings to New York State Department of Health timely. The facility reported their investigation findings on 03/10/2025 at 3:58 PM.2) the facility Accident/Incident Report dated 08/17/2024 documented that Resident #8 and Resident #9 had a verbal altercation in the dining room and Resident #9 picked up a fork and threatened to stab Resident #8. Staff immediately intervened and separated the residents and took the fork from Resident #9. The facility investigated and reported the incident to New York State Department of Health but did not submit the five (5) days investigation findings to New York State Department of Health. The findings include: The Facility's Policy and Procedure titled Prevention of Mistreatment, Neglect and Abuse and Misappropriation of Resident Property with a reviewed dated 01/2024 documented the Director of Nursing/Administrator will report to the Department of Health, within two (2) hours of any accidents/incidents where there is reasonable cause to believe that resident abuse, neglect or mistreatment has occurred. The facility has five (5) days to complete its investigation and report the findings. Resident #7 was admitted to the facility with diagnoses including Depression and Diabetes Mellitus. The Minimum Data Set (a resident assessment tool) dated 02/13/2025 documented Resident #7 had severely impaired cognition.The facility's Investigation Summary dated 03/01/2025 documented that Resident #7's family member reported to Licensed Practical Nurse #3 on 03/01/2025 at 5:00 PM that two (2) Certified Nursing Assistants who were roughed with Resident #7 early in the morning. Registered Nurse Supervisor #2 interviewed Resident #7 on 03/01/2025 via interpreter and the resident reported that Certified Nursing Assistant #2 held them by their neck and another (unidentified) Certified Nursing Assistant pulled their feet. Resident #7 was assessed and there was no redness, bruising or any marks observed on the resident's neck and feet. Resident #7 did not complain of pain. The police were notified and responded but did not make any report. Resident #7's assigned Certified Nursing Assistant #2 provided care to Resident #7 and Licensed Practical Nurse #2 assisted Certified Nursing Assistant #2 in repositioning the resident in bed. There was no other Certified Nursing Assistant who assisted Certified Nursing Assistant #2 during their care. The facility's investigation concluded that abuse did not occur. Resident #7 had poor recall and may have assumed that they were mishandled when they were receiving regular activities of daily living care. To prevent reoccurrence, the facility in-serviced the staff on gentle handling of residents and using a translation line communication with residents who speak a different language for clear communication. The facility completed their investigation and concluded that abuse did not occur. During a telephone interview on 08/26/2025 at 9:45 AM, the previous Director of Nursing #1 stated that they do not recall the incident. The previous Director of Nursing #1 stated that they do not know why the five (5) days report was submitted late. During an interview on 08 /25/2025 at 2:20 PM, the Administrator stated that they were notified of the incident by the previous Director of Nursing on 03/01/2025 (unsure of time) but was not aware the five (5) days investigation findings were submitted late. Resident #8 was admitted to facility with diagnoses including Depression, Chronic Kidney Disease and Diabetes Mellitus. The Minimum Data Set (a resident assessment tool) dated 06/25/2024 documented that Resident #8 had intact cognition.Resident #9 was admitted to facility with diagnoses including Diabetes Mellitus and Adjustment Disorder with mixed Anxiety and Depressed Mood. The Minimum Data Set, dated [DATE] documented Resident #9 had intact cognition.The facility's Investigation Summary dated 08/23/2024 documented that on 08/17/2024 at 8:40 AM Resident #8 and Resident #9 were seated at a distance from each other in the dining room. For reasons unknown, Resident #8 and Resident #9 had a