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	01/23/2026

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interviews conducted during the Recertification survey conducted from 09/15/2026 to 09/23/2026, the facility did not ensure sufficient nursing staff was consistently provided to meet the residents' needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care. Specifically, 1). Residents and staff reported the facility was short staffed with Certified Nursing Assistants and Licensed Practical Nurses especially on weekends both days and nights, which resulted in delays in performing Activities of Daily Living and personal care. 2). The facility Payroll Based Journal for Quarter 4 (July -September 2025) also revealed excessively low weekend staffing, and 3). Review of the actual staffing schedules dated from 07/01/2025 to 09/30/2025 revealed that staffing assignments were consistently less than the projected staffing needs specified in the Facility Assessment.The findings include but are not limited to: The Payroll Based Journal Staffing Data Report for the 4th quarter of 2025 (07/01/2025 - 09/30/2025) documented that low weekend staffing was triggered.The Facility Wide Assessment which was last updated on 01/2025 documented that the Facility Assessment was intended to evaluate the facility's population and determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. The facility provides care on 5 units on Floors 2 through 6 with a 213-bed capacity. Each unit has a capacity of 43 beds. There are differentiations in the resident population and focus of services provided on each of the floors. The staffing plan for each of the floors that provides direct care to the residents is based upon an assessment of the care needs of the residents.The focus of service for the 2nd Foor unit was documented as high acuity residents who required total dependence for daily living Activities and residents with enteral tube feedings.The focus of service for the 6th Floor unit was short term care residents who had fractures and / or joint replacements requiring rehabilitation services, residents who required short term intravenous therapy. The unit also included long-term care residents in need of skilled nursing services.The documented Staffing Requirement/ par level for the 2nd Floor and 6 Floor units were two (2) Licensed Practical Nurses providing direct care on all shifts and five (5) Certified Nursing Assistants on day shift.The par levels for nursing staff as documented in the Facility Assessment were as follows:Day Shift (7:00 AM - 3:00 PM):2nd Floor (bed capacity of 43) : 2 Licensed Practical Nurses, 5 Certified Nursing Assistants3rd Floor (bed capacity of 43): 2 Licensed Practical Nurses, 4 Certified Nursing Assistants4th Floor (bed capacity of 43): 2Licensed Practical Nurses, 4 Certified Nursing Assistants5th Floor (bed capacity of 43): 2Licensed Practical Nurse, 4 Certified Nursing Assistants6th Floor (bed capacity of 43): 2 Licensed Nurses, 5 Certified Nursing Assistants Evening Shift (3:00 PM - 11:00 PM):2nd Floor: 2 Licensed Practical Nurse, 4 Certified Nursing Assistants3rd Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants4th Floor: 1 Licensed Practical Nurses, 3 Certified Nursing Assistants5th Floor: 1 Licensed Practical Nurses, 3 Certified Nursing Assistants6th Floor: 2 Licensed Practical Nurses, 3 Certified Nursing Assistants Night Shift (11:00 PM - 7:00 AM):2nd Floor: 2 Licensed Practical Nurses, 3 Certified Nursing Assistants3rd Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants4th Floor: 1 Licensed Practical Nurse, 2 (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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified Nursing Assistants5th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants6th Floor: 2 Licensed Practical Nurse, 2 Certified Nursing Assistants A review of the weekend staffing schedule from Quarter 4 of 2025 (07/01/2025 - 09/30/2025) documented the following consistently low weekend staffing which was representative of staffing levels in additional months.The documented staffing requirement / par level for the 2nd Floor and 6th Floor units were the highest facility requirement with two (2) Licensed Practical Nurses providing direct care on all shiftsand five (5) Certified Nursing Assistants providing direct care on the day shift, which was often not met. 07/5/05/2025 (Saturday), Day Shift, Shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units07/06/2025 (Sunday), Day Shift, Shortage of one (1) Licensed Practical Nurse 3rd, 4th, and 5th Floor units07/06/2025 (Sunday), Night Shift, Shortage of one (1) Licensed Practical Nurse on the 6th Floor unit07/11/2035 (Friday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd Floor unit; and shortage of one (1) Certified Nursing Assistants on the 2nd, 4th, and 6th Floor units.07/11/2035 (Friday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 6th Floor unit07/12/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, 5th, and 6th Floor units07/12/2025 (Saturday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 2nd Floor unit07/13/2025 (Sunday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, 5th, and 6th Floor units; and shortage of one (1) Certified Nursing Assistant on the 2nd, 4th, 6th Floor units.07/13/2025 (Sunday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 2nd Floor.07/18/2025 (Friday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units07/18/2025 (Friday), Night shift, shortage of one (1) Licensed Practical Nurse on the 6th Floor07/19/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units07/19/2025 (Sunday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 2nd and 6th Floor units07/20/2025 (Sunday), Day Shift, Shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units; and one (1) Certified Nursing Assistant on the 6th Floor07/20/2025 (Sunday), Night shift, Shortage of one (1) Certified Nursing Assistant on the 6th Floor unit07/26/2025 (Saturday), Day Shift, Shortage of one (1) Licensed Practical Nurse on the 3rd floor unit, 4th floor unit, 5th floor unit07/26/2025 (Saturday), Night Shift, Shortage of one (1) Certified Nursing Assistant on the 2nd Floor unit08/02/2025 (Saturday), Day Shift, shortage of one (1) Licensed Practical Nurse on the 3rd floor unit, 4th floor unit, and 5th floor unit08/02/2025 (Saturday), Night Shift, Shortage of one (1) Licensed Practical Nurse on the 2nd and 6th Floor units08/03/2025 (Sunday), Day Shift, Shortage of one (1) Licensed Practical Nurse on the 2nd, 3rd, 4th, and 5th Floor units08/03/2025 (Sunday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 6th Floor unit; and one (1) Shortage of 1 Certified Nursing Assistant08/08/2025 (Friday), Day shift, shortage of one (1) Certified Nursing Assistant on the 6th Floor unit 08/09/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor unit 08/10/2025 (Sunday), Day shift, shortage of one (1) Licensed Practical Nurse on the 2nd, 3rd, 4th, 5th, and 6th Floor units08/10/2025 (Sunday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 2nd, 3rd, 4th, 5th, and 6th floor units08/23/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units08/30/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on the 3rd, 4th, and 5th Floor units 0/30/2025 (Saturday), Night shift, shortage of one (1) Certified Nursing Assistant on the 2nd Floor unit 09/13/2025 (Saturday), Day shift, shortage of one (1) Licensed Practical Nurse on 3rd, 4th, and 5th Floor units09/13/2025 (Saturday), Evening shift, shortage of one (1) Licensed Practical Nurse on the 6th Floor unit 09/14/2025 (Sunday), shortage of one (1) Licensed Practical Nurse on the day shift in 3rd, 4th, and 5th Floor units; shortage of one (1) Certified Nursing Assistant on the evening shift in 6th Floor; and shortage of one (1) Licensed Practical Nurse on the night shift in 2nd Floor On 01/15/2026 at 11:10 AM, Resident #53 was interviewed and stated that they have been missing therapy sessions. They stated sometimes the staff change/dress/bathe them after breakfast and by the time the aides come to help them dress and bathe, their already late for rehabilitation (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapy. Resident #53 also stated they missed rehabilitative therapy sessions. Resident #53 stated that staffing is short during the nights, morning and basically all the time. There are people waiting for care and the aides are rushed. Resident #53 further stated that they also wait for care and then miss their appointmentOn 01/15/2026 at 11:57AM, Resident #158 was interviewed and stated that the facility is short in staff. There are times when there is have one nurse for the whole floor. Resident #158 stated they sometimes get their morning medications an hour later that they were supposed to. On 01/21/2026 at 9:56 AM, Licensed Practical Nurse #3 was interviewed and stated that they are short of nurses since 2024 and that the 6th floor which was a rehabilitation unit is inadequately staffed. They stated that two (2) person transfers cannot be performed timely with only three (3) aides during the day when they were supposed to have five (5). On 01/21/2026 at 1:08 AM, Certified Nursing Assistant #4 was interviewed and stated that 6th Floor is short staffed and that at times, another aide is floated to another unit leaving the 6th Floor short. They stated there are residents that required 2 people assist in transfers aside from long term care residents who are total care. They stated that there are short staffing on the evening shift as well and residents who required Hoyer lift for transfers stay in bed, and that day showers are pushed to the evening shift. On 01/23/2026 at 1:29 PM, Certified Nursing Assistant #5 was interviewed and stated that staffing is low even on weekdays on the 6th Floor with only 4 aides to take care of 43 residents. Certified Nursing Assistant #5 further stated that residents who require Hoyer lift for transfers are showered on different days because other aide gets floated to a different floor who have lesser staff. On 01/23/2026 at 12:19 PM, the Staffing Coordinator was interviewed and stated that they are aware of the short staffing and that the facility is mostly short of aides in the day shift. They stated that 2nd and 6th Floors have residents with higher acuity and need more staff. They stated they are able to obtain staff but sometimes there are call-outs. They also stated that they have nurses and aides who are on-call but there is only 50% chance that the shift will be filled up to par. On 01/23/2026 at 1:40 PM, Registered Nurse #5, who was the 6th Floor supervisor was interviewed and stated that 6th Floor staffing is usually up to par, but other floors are short and their staff will be floated somewhere else. They stated that shower schedules are sometimes moved to the evening shift or there might be a delay in getting resident out of bed. On at 01/23/2026 12:56 PM, the Director of Nursing was interviewed and stated they are aware of the facility's past and present staffing issues, and they have been hiring aggressively using 12 different staffing agencies. They stated that although weekend staffing had improved, there are still issues on weekends and days possibly related to staffing agencies bidding wars. The Director stated that at times, staff are floated to a different unit, and that the staff on the 6th Floor are the ones usually floated because they are reliable and had solid experience. On 01/23/2026 at 2:31 PM, the Administrator was interviewed and stated they are aware of the facility's low weekend staffing and was informed of current staffing complaints. They stated that the facility could not recruit enough staff to make the par level.10 NYCRR 415.13(a)(1) (i-iii)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure residents remained free from physical restraints. This was evident for one (1) of two (2) (Resident #222) residents reviewed for Restraints out of 38 total sampled residents. Specifically, bed bolsters were used for Resident #222 without assessment, physician's order, and consent. The findings are:The facility's policy titled Prevention of Mistreatment, Neglect, Abuse, and Misappropriation of Resident with a last revised date of 01/2024 documented every resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. It also documented the facility will ensure no action will be taken to control the resident's behavior or manage a resident's behavior with a lessor amount of effort by the facility and not in the best interest of the resident.Resident #222 had diagnoses of Unspecified dementia, Alzheimer's disease, and Fracture of unspecified part of neck of left femur.The admission Minimum Data Set assessment dated [DATE] documented Resident #222 was severely impaired in cognition. It also documented no physical restraint, or alarm was used for Resident #222. It further documented only Resident #222's representative participated in the assessment. Between 01/15/2026 at 10:51 AM and 01/21/2026 at 9:45 AM, there were multiple observations of Resident #222 lying in bed with bilateral upper side rails raised and bed bolsters placed beneath the bed sheet on both sides of lower half of bed.On 01/15/2026 at 10:51 AM, Resident #222's representative was interviewed and stated only the upper side rails were used when Resident #222 was admitted to the facility on [DATE]. They stated this was the first time they observed the bed bolsters tucked under the sheet. The representative stated the facility did not notify them about the use of bed bolsters.A physician's order dated 01/12/2026 documented Resident #222 was ordered to use bilateral one-half side rails/enablers up in bed to promote increased bed mobility.The Nursing - Side Rail assessment dated [DATE] documented side rails were used as enabler rail and to avoid Resident #222 from rolling out of bed.The nursing note dated 01/12/2026 documented Resident #222 was noted sitting at the edge of bed.A Comprehensive Care plan related to falls that was initiated on 01/09/2026 documented an intervention of adding bilateral bed bolsters and floor mats on 01/15/2026 as Resident #222 tried to come out bed and was at risk of fall. The Certified Nursing Assistant tasks in the computer system documented floor mats, low bed, and wedge cushions as protective measures for safety on 01/16/2026 for Resident #222.There were no physician's order, assessment, and notification to representative to use bed bolsters for Resident #222 in the medical record.On 01/21/2026 at 10:43 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #222 was alert and confused. The Certified Nursing Assistant #1 also stated Resident #222 had upper bed side rails up all the time and that they placed the bed bolsters on the bilateral lower half of Resident #222's bed as per nurse instruction in their tasks to prevent Resident #222 from rolling out of bed. Certified Nursing Assistant #1 stated the bed bolsters were attached to the mattress and were placed under the sheet. Certified Nursing Assistant #1 also stated Resident #222 was unable to remove the bed bolsters or lower down the upper side rails to get out of bed by themselves.On 01/21/2026 at 11:06 AM, Registered Nurse #1 was interviewed and stated there was a time when Resident #222 placed their lower extremities out of bed. They were concerned that Resident #222 would fall out of bed, so they had decided to place the bed bolsters on both lower sides of bed to prevent Resident #222 from rolling out. Registered Nurse #1 further stated Resident #222 was unable to get out of bed when upper side rails were raised and when the bed bolsters were placed on the lower half of the bed. Registered Nurse #1 stated they did not conduct restraint assessment, they did not obtain consent from the representative, nor obtain physician's order prior to placing the bed bolsters. On 01/21/2026 at 11:41 AM, Occupational Therapist #1 was interviewed and stated Resident #222 had fine motor issue and decreased strength. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Occupational Therapist #1 stated Resident #222 was unable to lower the upper side rails or get out of bed by themselves when the upper side rails were raised and when bed bolsters were placed on both sides of the bed. On 01/21/2026 at 11:44 AM, Physical Therapist #1 was interviewed and stated Resident #222 had muscle weakness and problem with standing balance. Physical Therapist #1 also stated Resident #222 was unable to get out of bed by themselves when the upper side rails were raised and when bed bolsters were in use. On 01/21/2026 at 2:39 PM, Nurse Practitioner #1 was interviewed and stated Resident #222 only had the medical order for using upper side rails. The Nurse Practitioner #1 also stated they did not order nor was aware of the use of bed bolsters.On 01/21/2026 at 11:51 AM, the Director of Nursing was interviewed and stated they were not aware bed bolsters were applied for Resident #222 without medical order, assessment, and consent. The Director of Nursing stated a restraint assessment must be completed before putting the bed bolsters; they also stated that there must be physician's order and consent from the resident representative. They stated Resident #222 would not be able to get out of bed by themselves when the upper side rails were raised and when bed bolsters were used. The Director of Nursing also stated the use of upper bed side rails and bed bolsters at lower bed would be physical restraint for Resident #222. 10 NYCRR 415.4(a)(2-7)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that all alleged violations involving injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, to the New York State Department of Health. This was evident for one (1) (Resident # 180) of five (5) residents reviewed for Accidents out of 38 total sampled residents. Specifically, on 01/09/2026 at approximately 9:07 PM, Resident #180 was observed sitting on the floor in the hallway with a large hematoma (a collection of clotted blood outside of the blood vessel usually caused by trauma) with an open laceration on the temple and abrasion to the left elbow. There was no witness on how Resident #180 sustained the injury and the source of injury could not be explained by the resident. The findings include:The facility's policy and procedure titled Prevention of Mistreatment, Neglect, Abuse and Misappropriation of Resident Property with a last reviewed date of 01/2024 documented all incident/accident of unknown origin will be thoroughly investigated and reported to the Department of Health within the required timelines.Resident #180 had diagnoses of acute ischemic heart disease, history of falling, and dementia.The quarterly Minimum Data Set assessment dated [DATE] documented Resident #180 had severely impaired cognition and required partial to moderate assistance for activities of daily living. On 01/16/2026 at 9:52 AM, Resident #180 was observed seated in a wheelchair, in the dining room. The left side of the face had a large and mostly fading yellowish/greenish skin discoloration. Resident #180 was unable to state how they sustained the facial discoloration. The Accident / Incident Report documented that on 01/09/2026 at 9:07 PM, Resident #180, who was cognitively impaired, was observed in the hallway, sitting on the floor, outside their room. A large hematoma and a two (2) - three (3) centimeter laceration was noted on their left temple and abrasion to the left arm near elbow was noted. Resident #180 was transferred to the emergency room. The nurse's progress notes dated 01/09/2026 at 10:42 AM documented Resident #180 was unable to verbalize how they ended on the floor. The Summary of Investigation by the Director of Nursing dated 01/13/2026 concluded that the element needed to make this incident reportable to the Department of Health have not been met. On 01/22/2026 at 10:31 AM, the Director of Nursing was interviewed and stated that the Department of Health Incident Reporting manual was used and reviewed to provide guidance on how or what to report to the Department of Health. They stated the incident was not an injury of unknown origin, there was no care plan violation, and there was no serious injury such as fracture. On 01/23/2026 at 10:42 AM, the Administrator was interviewed and stated that injuries of unknown origin that cannot be explained must be reported to the Department of Health. 10 NYCRR 415.4 (b)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to develop a person-centered comprehensive care plan to meet each resident's preferences and goals; and address the resident's medical, physical, mental and psychosocial needs. This was evident for one (1) (Resident #8) of one (1) resident reviewed for activities out of 38 total sampled residents. Specifically, Resident #8's care plan for recreational activities was not initiated when the resident was readmitted to the facility after hospitalization. The findings include:The facility's policy and procedure titled Comprehensive Care Plans dated 10/2025 documented that Comprehensive Care Plans shall be periodically reviewed and revised as necessary after each comprehensive assessment or reassessment.Resident #8 was re-admitted to the facility on [DATE] with diagnoses which included Coronary Artery Disease, Heart Failure, and Renal Insufficiency. The Significant change Minimum Data Set assessment dated [DATE] documented Resident #8 was moderately impaired in cognition. The assessment also documented that resident's preferences for customary routine and activities were very important.The resident admission, transfer, and discharge records dated 09/02/2025 documented that Resident #8 was transferred to the hospital on [DATE] and was re-admitted to the facility on [DATE].The Activities - Recreation assessment dated [DATE] documented that the resident's activity preferences include arts and crafts, beauty hours, sewing and knitting, and watching television.A review of Resident #8's comprehensive care plans revealed that a care plan to address activities / recreation was not initiated when Resident #8 was readmitted to the facility on [DATE]. A therapeutic recreation care plan was only initiated on 01/23/2026. On 01/23/26 at 10:13 AM, an interview was conducted with the Recreation Director. They stated that activity care plans are initiated on admission, readmission, and if there is any change in the health status of a resident. The Recreation Director stated that Resident #8's care plan for activities / recreation was discontinued when the resident was transferred to the hospital on [DATE]. The resident was re-admitted to the facility on [DATE] and the care plan for activities was not reactivated. On 01/23/2026 at 12:20 PM, an interview was conducted with the Director of Nursing who stated that the Recreation Department is responsible for initiating each resident's care plan on activities. 10 NYCRR 415.11(c)(1)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, record review, and interviews, the facility failed to ensure notice of the availability of the survey results were posted in areas of the facility that are prominent and accessible to the residents and the public. Specifically, there were no posted notices throughout the five (5) resident floors of the facility about the availability of survey results. The findings are:The facility's policy titled Your Rights As A Nursing Home Resident dated August 2005 documented under Access to Information of Life at the Facility that residents have the right to examine the results of the most recent federal or state survey of the facility including any statement of deficiencies, any plan of correction in effect with respect to the facility and any enforcement actions taken by the New York State Department of Health. It also documented the results must be made available for examination in a place readily accessible.During multiple building observations conducted between 01/15/2026 at 09:43 AM and 01/16/2025 at 10:50 AM, survey results were observed in a binder in a plastic container installed on the wall across the security station in the lobby area. There were no notices posted to inform the residents and the public on any of five (5) resident units about where the survey results could be located. During the Resident Council meeting held on 01/16/2026 at 11:00 AM, seven (7) residents were in attendance, and seven (7) out of seven (7) residents (Residents #22, #63, #90, #164, #171, #208, and #211) stated they did not know where to find the survey results and that they have not seen any notice telling them where to find the survey results. The minutes of the Resident Council Meetings held on 10/20/2025, 11/25/2025, and 12/30/2025 had no documentation that information was provided to the residents on where to locate survey results. On 01/21/2026 at 12:13 PM, the Administrator was interviewed and stated they made round to the floors at least one (1) time every day. The Administrator also stated they looked for medication cart if resident information on the computer screen was displayed to residents/visitors passed by, if the staff had identity card on, and if the residents were clean. The Administrator stated they thought the posts where to find the survey results were posted on all the resident floors. The Administrator also stated they did not pay attention to the post when making round to the resident units. The Administrator stated the facility should post throughout the building to inform residents and the public where to find the survey results on the units. 10 NYCRR 415.3 (d)(1)(v)

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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rebekah Rehabilitation 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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the Minimum Data Set Assessments were electronically transmitted to the Centers of Medicare/Medicaid Services Data System within 14 days of completion. This was evident for nine (9) of 9 residents' (Residents #5, #15, #69, #124, #8, #180, #166, #155, #144) Minimum Data Set assessments. Specifically, these residents Minimum Data Set Assessments were not electronically transmitted within 14 days after the facility completed the resident's assessment. The findings include but are not limited to: The facility's policy titled Minimum Data Set with an effective date of12/2024 did not include procedure on when to submit completed Minimum Data Set assessments to the Centers for Medicare & Medicare Services.1) Resident #5 was admitted on [DATE]. The Centers of Medicare/Medicaid Services Submission Report Minimum Data Set 3.0 Nursing Home Final Validation Report, the target date for the Quarterly Minimum Data Set was 11/26/2025. The Quarterly Minimum Data Set was submitted on 01/19/2026. The report also documented Record Submitted Late: the submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment.2) Resident #15 was admitted on [DATE]. The Centers of Medicare/Medicaid Services Submission Report Minimum Data Set 3.0 Nursing Home Final Validation Report, the target date for the Quarterly Minimum Data Set was 12/08/2025. The Quarterly Minimum Data Set was submitted on 01/19/2026. The report also documented Record Submitted Late: the submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment.3) Resident #69 was admitted on [DATE]. Per Centers of Medicare/Medicaid Services Submission Report Minimum Data Set 3.0 Nursing Home Final Validation Report, the target date for the Annual Minimum Data Set was 12/01/2025. The Annual Minimum Data Set was submitted on 01/19/2026. The report also documented Record Submitted Late: the submission date is more than 14 days after V0200C2 on this new (A0050 equals 1) comprehensive assessment.On 01/22/2026 at 10:45 AM, the Minimum Data Set Director was interviewed and stated they were responsible for completion and submission of Minimum Data Set assessments to Centers of Medicare/Medicaid Services. They stated they were the only staff able to submit the completed Minimum Data Set assessments. The Minimum Data Set Director also stated they were on vacation from 12/09/2025 to 01/06/2026 and they failed to train the Minimum Data Set assessor to submit the Minimum Data Set in the Internet Quality Improvement and Evaluation System before they went on vacation. On 01/22/2026 at 12:30 PM, the Administrator was interviewed and stated they were not aware that the Minimum Data Set assessments were submitted late. 10 NYCRR 415.11