STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045361	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Promenade Health and Rehabilitation	1101 S Promenade Boulevard Rogers, AR 72758

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 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 observations, interviews, facility document review, and facility policy and procedure review, the facility failed to ensure residents were free from physical restraints, for 1 (Resident #82) of 2 residents reviewed. Based on facility document review, interviews and facility policy review, the facility failed to ensure residents were free from physical restraints, for one (Resident #82) of two residents reviewed. The findings include: Review of the Facility's Incident Report involving Resident #82 on 12/15/2025, indicated that on 04/16/2025 during the evening shift, no time specified, per Certified Nursing Assistant (CNA) #2's witness statement, upon entrance into Resident #82's room CNA #3 and CNA #4 were tying a sheet around resident's waist and to the back of the chair. Licensed Practical Nurse (LPN) #5 was also in the room with the resident at the time the incident occurred. CNA #2 reported the incident to Lead Certified Nursing Assistant (LCNA) #1 on 04/17/2025 at 6:00 PM. LCNA #1 immediately reported the incident to the Director of Nursing (DON) and the Administrator. The Administrator reported the incident to appropriate authorities, and called in the involved staff (LCNA #1, CNA #2, CNA #3, CNA #4, LPN #5). All involved staff provided witness statements, and CNA #3, CNA #4 and LPN #5 were suspended pending the outcome of the investigation. Body Audits and Psychosocial Assessments were taken of Resident #82 with no negative outcome. Abuse and Neglect in-services were initiated specifically on physical restraints. The facility Incident Report indicated that CNA #3 stated Resident #82 had been very agitated and hitting at staff, so a folded sheet was placed in Resident #82's lap and tucked in the chair to make the resident feel secure. According to CNA #3, this was done with the assistance of two other staff members. CNA #4's witness statement indicated that Resident #82 had behaviors of aggression on the evening of the alleged incident and CNA #4 along with two other staff members had tucked a blanket around Resident #82 while in a chair. CNA #4 also indicated in the witness statement that Resident #82 had expressed being cold prior to the blanket being tucked in. LPN #5 provided a witness statement that stated nothing unusual was observed while giving Resident #82 medications on the shift. Resident #82 had been cold, and the staff provided blankets to the resident while the resident was sitting in the chair in the bedroom. The findings of the facility's investigation indicated that the accused staff, CNA #3, CNA #4, and LPN # 5, were terminated from employment with the facility. Discharge Minimum Data Set (MDS) dated [DATE] indicated Resident #82 had a Staff Assessed Mental Status (SAMS) score of 03, which indicated severe cognitive impairment. The MDS also indicated the resident had medical diagnoses which included dementia with anxiety. The MDS did not indicate that the resident had an order for physical restraints. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #82's Progress Notes prior to the incident indicated that the resident had episodes of agitation and anxiety that included yelling out and striking at staff. Review of Resident #82's Care Plan with revised date of 07/08/2025, indicated that the resident had not been care planned for physical restraint use. Review of a Police Report with a reported date of 04/17/2025 at 5:51 PM indicated, the Administrator made the report to the police department stating that CNA #3, CNA #4, and LPN #5 had been involved in physically restraining Resident #82 to the chair in the bedroom with a bed sheet. The report indicated an investigation had begun with witness statements from the accused and suspension from employment pending the outcome of the investigation. Psychosocial and Skin Audits were initiated on the resident, witness statements from residents and staff were obtained and re-education and in servicing on the abuse and neglect policies which included physical restraints were completed. Review of CNA #3, CNA #4 and LPN #5's Personnel Files indicated that a Restraint Guidance was reviewed and signed by staff upon hire. The Restraint Guidance indicated that the facility strives to be restraint free, however in unusual and extreme circumstances, restraints may be considered. The Restraint Guidance stated, Physical restraints will not be used to limit patient's mobility for convenience of staff, and Restraints will only be used when authorized in writing by physician for a specified and limited period of time except in emergencies when DON or Charge Nurse authorize use until physician is contacted. Review of an in service titled Abuse and Neglect dated 01/31/2025, indicated Physical Restraints was included in the education and was signed by CNA #3, CNA #4, and LPN #5. During an interview on 12/17/2025 at 11:23 AM, LCNA #1 confirmed that staff at the facility are educated and in-serviced on restraints and that this facility did not have residents with care planned restraints. LCNA #1 also recalled the incident regarding Resident #82 and stated that CNA #2 had reported to LCNA #1 that three staff, two CNAs and one nurse was involved in what appeared to be physical restraint usage. LCNA #1 described Resident #82 as having dementia with agitation which sometimes included being combative towards staff as well as yelling out. During an interview on 12/17/2025 at 11:43 AM, CNA #2 recalled the incident involving CNA #3, CNA #4, and LPN #5. CNA #2 stated that upon entering Resident #82's room, CNA #3 and CNA #4 were tying a sheet around the resident's waist and to the back of the chair while LPN #5 observed. CNA #2 stated she reported the incident to LCNA #1 on the following shift. During an interview on 12/17/2025 at 12:13 PM, LPN #5 recalled the incident but denied having participated or observed anything abnormal or against policy. LPN #5 stated that Resident #82 was covered with a blanket because earlier the resident had expressed being cold. During an interview on 12/17/2025 at 2:22 PM, the Assistant Director of Nursing (ADON) recalled the incident and doing skin audits on Resident #82. The ADON stated re-education was provided to the staff involved on how to handle agitated residents. The ADON confirmed that all facility staff are educated and in-serviced on restraint usage. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2025 at 8:35 AM, the DON confirmed that LCNA #1 reported the alleged physical restraint incident involving Resident #82 and that the facility conducted an internal investigation. The DON stated that Resident #82 was assessed, a body audit was conducted, and the accused staff members were interviewed and suspended. The DON stated that CNA #3 and #4 stated a blanket was put on Resident #82 while in a chair in the bedroom and that LPN #5 denied being present during the incident. The DON stated camera footage indicated LPN #5 was present in the room during the incident. The DON confirmed that all three staff members accused were terminated from employment. During an interview on 12/18/2025 at 10:31 AM, the Administrator stated that the incident involving Resident #82 being allegedly restrained was reported on 04/17/2025 by LCNA #1. The staff accused, CNA #3, CNA #4, and LPN #5, were immediately contacted, interviewed, witness statements were taken, and the staff members were suspended pending the outcome of the investigation. The Administrator stated that the three accused staff members were terminated from employment with the facility based on the inability to prove that the incident occurred as reported. Review of a facility policy titled Abuse and Neglect revised on 08/10/2022 indicated the policy read in part, The facility is charged with the safeguard of each resident and will follow a comprehensive plan of pursuit of maintaining a safe environment. Defines restraints as imposed for purposes of discipline or convenience that are not required to treat the resident's medical symptoms. Review of the facility's Residents' [NAME] of Rights revealed that residents will have freedom from abuse and restraints, and be free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time and only to protect resident from injury to self or others. The facility terminated CNA #3, CNA #4 and LPN #5 on 04/16/2025 per a termination checklist located in each employee file. The facility re-educated all staff on a Abuse & Neglect facility policy and procedure, as well as Restraint Usage, verified by the ADON and Employee Attendance Sign in Sheets for in-services. These actions were performed before the survey team entered the facility, resulting in this finding being cited at past non-compliance.