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

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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 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)

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. 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 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: Based on record review, observation, interview and facility policy review, the facility failed to ensure a mechanical lift was in safe operational condition prior to the lift and transfer of one (Resident #34) of one resident reviewed for mechanical lifts and transfers. The findings include: Review of Medical Diagnosis for Resident #34 indicated the resident had diagnoses which included hemiplegia [paralysis of one side of the body], kidney failure, and atrial fibrillation [irregular heart rhythm]. Review of a quarterly Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of11/06/2025 revealed, a Brief Interview of Mental Status [BIMS] score of 10, which indicated moderate cognitive impairment. The MDS also indicated Resident #34 was dependent on staff for toileting, personal hygiene, bathing and lower body dressing. Maximum assistance was required for dressing the upper body. Review of a Care Plan for Resident #34 revised 06/23/2022, indicated a self-care deficit related to limited mobility, paralysis on one side of the body, and balance impairment and that Resident #34 required a mechanical lift with two person assistance. Review of Certified Nursing Assistant [CNA] #7's Employee Record indicated, an in-servicing on mechanical lift use was done on 12/12/2023. CNA #8's Employee Record indicated, on 06/03/2025 CNA #8 was in-serviced on transfers including use of mechanical lifts. Part of the mechanical lift in-service included a return demonstration. Review of Transfer Competencies for CNA #8 dated 12/07/2025 and CNA #7 dated 12/03/2025 indicated during mechanical lift transfers staff assembles weight appropriate lift and sling, but the competency did not include assessing the equipment. During an observation on 12/15/2025 at 1:27 PM, CNA #8 was observed placing a mechanical lift around Resident #34's wheelchair with the legs of the lift in an open position. CNA #7 assisted in lifting Resident #34 with the mechanical lift and rolled Resident #34 in position over resident's bed. A metal clip on the arm of the lift used on the right side of the resident's upper body was noted to be missing from the hook. Resident #34 was lowered by CNA #8 to the bed with the legs of the mechanical lift in the open position, and rear casters unlocked. During an observation on 12/15/2025 at 1:35 PM, this surveyor observed the mechanical lift pushed against the left side of the wall on 200 Hall and asked CNA #7 and CNA #8 if they noticed anything of concern about the mechanical lift. CNA #7 stated It is missing a clip. CNA #8 confirmed there was a missing clip on the outer arm hook used to attach a lift pad when lifting a resident. CNA #8 stated the missing clip, is a safety measure that can keep the lift pad from slipping off the hook. CNA #7 and CNA #8 revealed the mechanical lift should not be used on a resident if not in good repair because (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidents can happen at any time. CNA #8 stated the lift had been sent out for repair and recently came back to the facility and was missing a clip at that time. CNA #7 stated they were not sure how long the metal clip had been missing from the arm hook, but it had been reported to maintenance and CNA #8 revealed the maintenance request was written in a Maintenance Log at the nurse's station. CNA #7 and CNA #8 agreed the mechanical lift should not have been used with a missing clip, and both reported in-service training on use of a mechanical lift. During an interview on 12/17/2025 at 11:50 AM, Licensed Practical Nurse [LPN] #9 confirmed that maintenance request was in a binder at the nurse's station. Review of the Maintenance Log revealed on 12/07/2025 a mechanical lift was reported as Weight [lift brand name] legs are opening by themselves, by the 7-3 shift. Maintenance documented Can't fix. [Proper] will replace them. LPN #9 revealed equipment not in good working order should be removed from service, and a missing clip concern could not be found in the Maintenance Logbook. During an interview on 12/17/2025 at 11:56 AM, the Administrator revealed three mechanical lifts had to be sent for repair and stated that a mechanical lift with a misting clip had been found on 200 Hall. The Administrator stated that the lift had been removed from service and [Proper] had brought a second lift for the facility to use, because they had at least 20 residents requiring a lift. The Administrator stated his expectation was equipment not in good repair would be removed from service and tagged for a safety perspective and Maintenance checks mechanical lifts monthly. Six months of lift inspections, and lift policy and/or procedures were requested. During an interview on 12/17/2025 at 12:50 PM, the Maintenance Director stated, I was notified that one of the lifts was missing a clip when it was discovered on 12/15/2025 and it was removed from service and [Proper] was contacted to repair the clip or mail a clip to maintenance for repair. Maintenance Director revealed the job of the missing clip was to prevent the lift pad from coming off the arm hooks while lifting or transferring a resident. The maintenance director stated It is a safety hazard to use a lift without a clip. If the strap moved while lifting a resident it could drop them. It is an added security for safety. During an interview on 12/18/2025 at 9:09 AM, the Medical Director stated he had not noticed any equipment not in good working order and would expect equipment in poor repair to be removed from service and not used on any resident because it would not be safe. During an interview on 12/18/2025 at 9:22 AM, the Director of Nursing [DON] stated, if something we use a lot like a mechanical lift is not working then staff should notify administration immediately, and it should be taken out of service. It would not be okay to use equipment not in good repair, because it is a resident safety issue. The DON stated staff, should put a sign on it that says broken, do not use and notify the Administrator, DON, and the maintenance worker and let the nurse know so she/he can write it in the maintenance book. Review of a policy titled, Safe Lifting and Movement of Resident, revised 03/24/2014, revealed mechanical lifts are used for heavy lifting to lift and transfer residents safely. Staff providing direct resident care should be trained in how to use the lift, and maintenance staff should perform routine checks and maintenance of equipment to make sure it is in proper working order. Review of a Mechanical Lift User Manual, dated 2022, revealed maintenance safety inspection includes a visual inspection for missing hardware. Bolt/hooks should be inspected for visual wear or damage. The hangar bar has three hooks that attach to the sling that provide support to the residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during lifting. It is important to inspect all stressed parts including the hangar bar for signs of cracking, fraying and deterioration. Replace any defective parts immediately and ensure the lift is not used until repairs are made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review observation, interview and facility policy review, the facility failed to ensure proper hand hygiene was maintained during perineal care for one (Resident #34) of one resident reviewed.The findings include:Review of Medical Diagnosis revealed, Resident #34 had diagnoses which included hemiplegia [paralysis of one side of the body], kidney failure, and atrial fibrillation [irregular heartbeat.] Review of a quarterly Minimum Data Set [MDS] with an Assessment Reference Date of 11/06/2025, revealed a Brief Interview of Mental Status score of 10, which indicated moderate cognitive impairment. The MDS also indicated Resident #34 was dependent on staff for toileting, personal hygiene, bathing, and lower body dressing.Review of a Care Plan for Resident #34 revealed a self-care deficit related to limited mobility, hemiplegia, and balance impairment (revised 06/23/2022), and that Resident #34 required two staff assistance for incontinent care. Review of a Perineal Care Competency for Certified Nursing Assistant [CNA] #8, dated 12/07/2025, and CNA #7, dated 12/03/2025, revealed staff would wash hands and change gloves after cleansing the pubic area and again after wiping the buttocks and across the sacrum. Staff would then apply a moisture barrier and wash and change gloves again. During an observation of perineal care for Resident #34 on 12/15/2025 at 1:27 PM, CNA #7 and CNA #8 put on gloves and assisted Resident #34 to residents' bed with a mechanical lift. CNA #8 removed a wet brief and threw it away, and then the lift pad was removed from under Resident #34 and CNA #8 rolled the lift pad up and set it to the side. CNA #8 proceeded to wipe the buttocks and sacral area with wipes in one direction. CNA #7 and CNA #8 did not change gloves or perform hand hygiene during the procedure. CNA #7 opened the drawer to the left side of the bed and removed a clean brief and placed it under Resident #34. Resident #34 rolled to his back and CNA #7 attached the tabs to the front of the clean brief. CNA #7 and CNA #8 removed a bag of trash and linens from the foot of the bed. CNA #7 adjusted the bed with controls and assisted CNA #8 in straightening the linens and clothing while touching bed rails and drawer to the left side of the bed, still wearing the same pair of dirty gloves. Both CNAs wore the same gloves throughout the entire procedure. During an interview on 12/15/2025 at 1:40 PM, CNA #8 stated during perineal care, We knock and sanitize hands, put on gloves, and place two trash bags at the foot of the bed. CNA #8 revealed he was doing the dirty role, and did not know why CNA #7 removed Resident #34's clean brief from the left bedside drawer and put the clean brief on Resident #34 without changing gloves and performing hand hygiene. CNA #7 confirmed she was supposed to keep her hands clean, and both CNA's confirm hand hygiene was not done during perineal care which was concerning for spreading germs. CNA #7 stated perineal care in-services are done at least once a year, and CNA #8 revealed every other month they receive training. During an interview with Director of Nursing [DON] on 12/18/2025 at 9:19 AM, the DON stated, CNAs should follow the directions of peri care competencies and they should wash their hands and glove up before peri care and change gloves during perineal care after cleaning the peri area and buttocks. The DON stated they should not touch any clean areas with their dirty gloves because of cross contamination. Review of a policy titled Perineal Care, revised 10/03/2026, revealed hands should be washed thoroughly and gloved before peri[[NAME]] care, and after cleaning the peri[[NAME]] area and/or buttocks soiled gloves should be removed and the hands washed thoroughly.