

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/09/2026
NAME OF PROVIDER OR SUPPLIER  Promenade Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  140 Beach 114th Street Rockaway Park, NY 11694	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that each resident received adequate supervision to prevent elopement. This was evident for one (1) out of three (3) residents (Resident #1) sampled for elopement. Specifically, on two (2) occasions Resident #1 exited the facility without the facility's knowledge and supervision. On 08/03/2025 at 5:57 PM, Housekeeping [NAME] #1 left the facility's exit back door alarm disabled and Resident #1 exited the facility without activating the alarm. Resident #1 was located at their adult sibling's house and transferred to hospital. Resident #1 returned to the facility on [DATE] at 9:15 PM with no injury. On 12/31/2025 at 2:25 AM, Resident #1 exited the front door after Security Guard #1 pressed the button at front desk to open the door and let Resident #1 out of the facility. Resident #1 was located by a family member on 01/01/2026 at 2:30 PM and was taken to the emergency room. Resident #1 returned to facility on 01/02/2026 at 3:47 AM without any injury. The findings include: The facility's policy and procedure titled, Elopement Prevention and Elopement dated 01/2025 documented it is the policy of the facility that residents will be maintained in safe and secure manner and protected from actual harm while encouraging a restraint free environment. The facility will make every positive effort to identify residents who have the potential for elopement. The facility's policy and procedure titled, Delivery Door Alarm Override dated 01/2025 documented it is the policy to ensure safety and security of residents, staff, visitors, and facility property while permitting necessary operational access through the delivery door. This policy establishes clear requirements for the controlled use of the delivery door alarm override key and is intended to prevent unauthorized access, resident elopement, and security breaches in compliance with New York State Department of Health regulations. The alarm override key may be utilized by authorized staff for operational purposes only and must be used in a manner that ensures continuous supervision of the door and immediate re-arming of the alarm once the task is completed. The morning porter and evening porter are authorized to utilize the delivery door alarm override key for deliveries and trash removal. Authorizations are limited to the performance of assigned duties and do not permit unsupervised or prolonged disarming of the alarm. The facility's policy and procedure titled Reception Logging In and Out, dated 01/2025 documented all visitors must log in upon entering and log out when leaving the facility in a logbook at the reception area. Receptionist/security guard/designee assigned at the reception area will assess all visitors for appropriate identity, are they a visitor resident. Do not allow anyone to leave the building without knowing if it is a visitor or a resident. Resident #1 was admitted to the facility with diagnoses including depression (mood disorder that causes feeling of sadness and loss of interest) and schizophrenia (serious mental illness that affects how a person thinks, feels and behaves). Incident 08/03/2025 The Minimum Data Set (an assessment tool) dated 07/24/2025 documented Resident #1 had intact cognition. Resident #1 ambulates with supervision or touching assistance. An admission elopement and unsafe wandering screen dated 07/17/2025 documented that Resident #1 was not at risk for elopement/wandering. A review of hourly rounds monitoring form dated 08/03/3035 at 5:00 PM, documented code 15 (observed in bed awake) for Resident #1 location. A (continued on next page)</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>review of facility digital video recording timeline of events dated 08/03/2025 (camera was not calibrated correctly, there is an hour, and 3 minutes delayed) on digital video recorder showed at 16:54:46 (5:54 PM real time) Resident #1 observed walking down the hallway and exited through the exit back door on the first floor. At 16:54: 58 (5:57 PM) Resident #1 exited through the back door.A review of the facility's internal investigation form dated 08/03/2025 at 7:15 PM, documented Licensed Practical Nurse #1 noted Resident #1 was not in their room prior to medication administration. A search was done on the unit and all other areas. Registered Nurse Supervisor #1 was notified at 7:25 PM and a head count was called on all units. At 7:45 PM, Resident #1 was not visible in the facility. The Director of Nursing and Administrator was notified and responded at 8:10 PM. Emergency number 911 was called and responded at 9:45 PM. The facility reviewed their surveillance recording and showed Resident #1 exited the facility ground through the exit back door at approximately 5:57 PM. At 10:10 PM, Resident #1's family member called the Administrator and stated Resident #1 was at their adult sibling's house. Resident #1 was transferred to hospital and returned to the facility on [DATE] at 9:15 PM in stable condition.A late entry nursing note dated 08/04/2025 at 1:10 AM by Registered Nurse Supervisor #1 documented notified by Licensed Practical Nurse #1 that prior to giving medications on 08/03/2025 approximately 7:15 PM, Resident #1 was missing from their room and further reported they checked/searched rooms, bathrooms, closets in the unit and stairs, Resident #1 could not be found. All units were notified. The Director of Nursing, Assistant Director of Nursing, Administrator, Medical Doctor and family member #1 were notified. 911 was called and responded at 9:45 PM. At approximately 10:25 PM, the administrator called that Resident #1 was found by their family member at Resident #1's adult sibling 's house. Resident #1 was transferred to emergency room for evaluation.A nursing note dated 08/04/2025 at 9:15 PM by Registered Nurse Supervisor #4 documented Resident #1 returned from the hospital at 9:15 PM with no recommendations. A wander alert guard was applied to Resident #1's left wrist.During an interview on 01/05/2026 at 12:39 PM, Housekeeping [NAME] #1 stated they worked in the evening shift (3:00 PM-11:00 PM) on 08/03/2025. Housekeeping [NAME] #1 stated they used the back door exit to throw the garbage in the designated container between 7:00 PM to 10:30PM. Housekeeping [NAME] #1 stated they have the key to the exit back door to disable the alarm. Housekeeping [NAME] #1 stated they remember locking the exit back door with their key. Housekeeping [NAME] #1 stated prior to the end of their shift they locked the exit back door. Housekeeping [NAME] #1 stated the exit back door has a code and other staff uses to exit the facility. Housekeeping [NAME] #1 stated they made sure they enabled the alarm after disposal of garbage but maybe they forgot to lock the exit back door and Resident #1 exited. Housekeeping [NAME] #1 stated they notified them that Resident #1 exited the back door to exit the facility. During an interview on 01/06/2026 at 1:13 PM, Certified Nursing Assistant #1 stated they were assigned to Resident #1 on 08/03/2025 on 3:00 PM-11:00 PM shift. Certified Nursing Assistant #1 stated Resident #1 was ambulatory and pleasant with all staff and residents. Certified Nursing Assistant #1 stated they observed Resident #1 approximately at 5:30 PM they finished their dinner and observed holding a coffee cup and went to the next door to other Resident's room. Certified Nursing Assistant #1 stated later the Licensed Practical Nurse #1 came to them and looked for Resident #1. Certified Nursing Assistant #1 stated they started searching for Resident #1 in their unit and even to other units but failed. Certified Nursing Assistant #1 stated Resident #1 did not show any signs of exit seeking behavior and they did not verbalize of wanting to go outside. Certified Nursing Assistant #1 stated because it was dinner time at that time Resident #1 took the opportunity to leave the unit without permission and they did not notice them. Certified Nursing Assistant #1 stated they did not suspect Resident #1 because they keep on saying they liked the facility. Certified Nursing Assistant #1 stated they visually monitored Resident #1 hourly in the unit. During an interview on 01/07/2026 at 10:21 AM, Registered Nurse Supervisor #1 stated they notified them on 08/03/2025 at approximately 7:20 PM by Licensed Practical Nurse #1 that Resident #1 was missing in the unit, and it could not be found despite initial searching. Registered Nurse (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Supervisor #1 stated they immediately called for headcount of all units (code butterfly initiated), immediate searches of in and out of the facility were conducted. Registered Nurse Supervisor #1 stated they notified 911, Director of Nursing, Assistant Director of Nursing, Administrator and family. Registered Nurse Supervisor #1 stated the administrator arrived in the facility and reviewed the video surveillance and showed that Resident #1 used the exit back door on the first floor without triggering the alarm. Registered Nurse Supervisor #1 stated the exit back door used by the housekeeping porter to dispose the facility's garbage to the designated container. Registered Nurse Supervisor #1 stated the door should alarm but because the housekeeping porter #1 disarmed the door alarm, Resident #1 exited the facility unsupervised, and the exit back door did not alarm. Registered Nurse Supervisor #1 stated Resident #1 was located within three (3) hours and transferred to hospital for evaluation and returned to facility in a stable condition. Registered Nurse Supervisor #1 stated Resident #1 was oriented three (3) times and able to make needs known. Registered Nurse Supervisor #1 stated they interviewed Resident #1, and they apologized for leaving without informing them because they wanted to speak to their adult sibling. Registered Nurse Supervisor #1 stated they placed a wander guard and Resident #1 was monitored every 30 minutes for safety. Incident dated 12/31/2025 The Minimum Data Set (an assessment tool) dated 10/24/2025 documented Resident #1 had intact cognition. Resident #1 ambulates with supervision or touching assistance. A comprehensive care plan for elopement-wandering initiated dated 08/04/2025 with interventions applied wander guard to check for placement every shift, wander guard check for placement and function by registered nurse in night shift (11:00 PM-7:00 AM) and to monitor Resident #1 every 30 minutes. The care plan was reviewed on 11/02/2025 with no changes. The Physician's order dated 08/05/2025 Resident #1 had ordered wander guard check for placement every shift, report if missing every eight (8) hours and wander guard check for placement and function every night shift. An elopement evaluation dated 11/07/25 at 10:01 PM documented Resident #1 had history of elopement and voices desire to leave. Resident #1 identified at risk for elopement. The Visual/Bedside Kardex Report dated 11/07/2025 documented Resident #1 was on hourly round monitoring and wander guard applied to left wrist, check placement/skin integrity and if missing and skin impairment observed, notify the nurse. A review of the hourly monitoring form revealed there was no documented monitoring performed for Resident #1 on 12/31/2025. The facility review of timeline of events from video surveillance recording dated 12/31/2025 revealed a digital video recording #1, at 2:19:03, Resident #1 leaves the unit and gets on the elevator. A digital video recording #2 (camera was not calibrated correctly- an hour and two (2) minutes delayed). At 3:25:28 (2:25 AM), Resident #1 appeared at the front desk walking towards the front door, wearing hat, blue jacket and jeans. At 3:25:34, Security Guard #1 clicked to unlock the door for Resident #1 to leave. At 3:25:50, Security Guard #1 stood up and went to front door to check whom they let out of the door. At 3:26:34 (2:26 AM), Security Guard #1 retrieved a box to use a doorstep so they can check who they let out of the building. At 3:28:20 (2:28 AM) Security Guard #1 returned to their seat at the front desk without reporting the incident. A digital video recording #3 (camera was off by 57 minutes) revealed at 3:21:38 Resident #1 appeared outside the front door. At 3:21:46, Resident #1 goes down the block. At 3:22:47, Security Guard #1 goes outside to look for who left the building. At 3:23:46, Security Guard #1 goes back inside the facility. A review of Internal investigation dated 12/31/2025 documented at approximately 3:00 AM, Certified Nursing Assistant #3 entered Resident #1's room to do their hourly checks and noted Resident #1 was not in their room and thorough search was done. Resident #1 was last seen in their room at 2:00 AM sitting on their bed. The Registered Nurse Supervisor #3 was notified, and a search of the whole building and surrounding areas was immediately done. 911 was notified and responded in ten (10) minutes. The Director of Nursing and Administrator arrived at the facility. The family was notified. The facility reviewed their surveillance recording and showed Resident #1 exited the facility through the front door wearing a thick blue jacket, a hat and blue jeans. Security Guard #1 let Resident #1 out because they do not look like a resident but then followed outside but no longer seen. A Certified Nursing Assistant who was in (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>their break inside their car did not recognized Resident #1. Security Guard #1 did not inform the Registered Nurse Supervisor #3 of the occurrence. Security Guard #1 was suspended pending investigation. On 01/01/2026 at approximately 2:30 PM, administrator received a call from family member #1 that Resident #1 was located at a store. 911 was notified and Resident #1 was transferred to hospital for evaluation. Resident #1 stated they left the facility because they had a misunderstanding with family member #1 and adult sibling #1. Resident #1 returned to facility on 01/02/2026 at 3:47 AM in stable condition. Resident #1 was placed on one-to-one supervision. Wander guard was applied. The facility concluded that there was no abuse, neglect and/or mistreatment identified. A nursing note dated 12/31/2025 at 6:34 AM by Licensed Practical Nurse #2 documented at approximately 3:00 AM Certified Nursing Assistant #3 notified them that Resident #1 was missing in their room, and their wander guard was left in their room. They immediately searched everywhere in the building without success. Licensed Practical Nurse #2 documented they called the Security Guard #1 at the front desk who reported that a man matched the description who left the building at approximately 2:40 AM. Licensed Practical Nurse #2 notified Registered Nurse Supervisor #3, 911 was called, family notified, and a missing resident was initiated. 911 responded. The family, assistant director of nursing, director of nursing and administrator were notified. During an interview on 01/05/2026 at 2:02 PM, Security Guard #1 stated they worked on 12/31/2025 from 12:00 midnight to 8:00 AM. Security Guard #1 stated when Resident #1 appeared in the lobby walking from approximately 2:20 to 2:25 AM. Security Guard #1 stated Resident #1 does not look like a resident in the facility. Security Guard #1 stated they asked them to sign but refused and they let them go out of the facility. Security Guard #1 stated when they realized why they let them go they stood up right away and followed them outside. Security Guard #1 stated they saw a staff member who was inside their car question them if they saw Resident #1 and they said they did not see them. Security Guard #1 stated then later a staff member looking for Resident #1. Security Guard #1 stated they notified Registered Nurse Supervisor #3 of the incident. Security Guard #1 stated they know the policy that any visitor that comes to the facility must sign in and sign out. Security Guard #1 stated that any staff or visitor cannot exit in the front door until the button is pressed or clicked out to exit by them. Security Guard #1 stated they were suspended from their work. During an interview on 01/07/2026 at 8:37 AM, Certified Nursing Assistant #3 stated they were assigned to Resident #1 on 12/31/2025 in the night shift (11:00 PM-7:00 AM). Certified Nursing Assistant #3 stated Resident #1 has wander guard in place when they did their rounds in the unit. Certified Nursing Assistant #3 stated Resident #1 was ambulatory and at approximately 1:30 AM, they observed Resident #1 walked to the vending machine to buy snacks and they went back to their room. Certified Nursing Assistant #3 stated Resident #1's had a routine of being awake around 1:00 AM to 3:00 AM to buy snacks, watch television and lay down in their bed. Certified Nursing Assistant #3 stated they checked Resident #1 approximately 2:00 AM, they were in their room sitting in bed watching television. Certified Nursing Assistant #3 stated at approximately 3:00 AM, they went to Resident #1's room to check after they attended care of other resident and did not see Resident #1 in their room. Certified Nursing Assistant #3 stated they notified Licensed Practical Nurse #2, and all staff checked the whole unit but were unsuccessful. Certified Nursing Assistant #3 stated they did not observe Resident #1 with signs of wanting to go outside or did not verbalize to them that they wanted to leave the facility. Certified Nursing Assistant #3 stated they found Resident #1's wander guard at their bedside. During an interview on 01/07/2026 at 8:24 AM, Registered Nurse Supervisor #3 stated they worked on 12/30/2025 from 11:00 PM to 7:00 AM. Registered Nurse Supervisor #3 stated they notified them by Licensed Practical Nurse #2 on 12/31/2025 approximately 3:15 AM that Resident #1 was in their room at 2:00 AM and while during their rounds at 3:00 AM, Resident #1 cannot be found. Registered Nurse Supervisor #3 stated they activated the elopement (code butterfly), and all units did head count, searching all units and surrounding areas of the facility. Registered Nurse Supervisor #3 stated when they saw security guard #1 approximately 3:30 AM, they asked them and provided description of (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1. Registered Nurse Supervisor #3 stated security guard #1 said the description matched Resident #1 that does not look like a resident, they were asked to sign out but refused and allowed to leave the facility. Registered Nurse Supervisor #3 stated the security guard #1 did not report the occurrence to them initially. Registered Nurse Supervisor #3 stated they notified 911, Director of Nursing, Assistant Director of Nursing, Medical Doctor, Administrator and family immediately. Registered Nurse Supervisor #3 stated Resident #1 was confirmed missing in the facility at approximately 3:30 AM. The police arrived at approximately 3:40 AM. Registered Nurse Supervisor #3 stated Resident #1 had their wander guard checked for functioning done prior to the incident. Registered Nurse Supervisor #3 stated they found the wander guard at Resident #1's bedside table cut off. During an interview on 01/02/2026 at 2:41 PM, Director of Nursing stated they were notified on 08/03/2025 incident approximately 7:45 PM by Registered Nurse Supervisor #1 and reported that Resident #1 was missing and cannot be found. Director of Nursing stated Resident #1 was identified not at risk for elopement and there were no signs of exit seeking behavior since their admission. Director of Nursing stated that through the help of family member #1 Resident #1 was located in their adult sibling #1's house. Director of Nursing stated 911 was called and taken Resident #1 to the hospital for evaluation. Director of Nursing stated the Housekeeping [NAME] #1 was suspended and eventually terminated. Director of Nursing stated Resident #1 eloped the second time and Resident #1 exited the facility ground when Security Guard #1 allowed Resident #1 to exit without identifying them prior pressing the button in their desk. Director of Nursing stated they observed Resident #1's wander guard's bracelet cut off and found at Resident #1's bedside table. Director of Nursing stated Resident #1 used a plastic butter knife to cut the wander guard bracelet. Director of Nursing stated to prevent the recurrence Resident #1 was placed to one-to-one supervision and to remove the plastic utensils after each meal. Director of Nursing stated they provided facility wide in-service to all staff on elopement prevention. During an interview on 01/07/2026 at 11:40 AM, Administrator stated they were aware of both incidents on 08/03/2025 and 12/31/2025 by Registered Nursing Supervisors #1 and #3. Administrator stated both incidents video surveillance recordings were reviewed right after the incident and confirmed that Resident #1 exited the facility ground unsupervised. Administrator stated after reviewing the video surveillance, they confirmed that Resident #1 exited the exit back door, and no alarm was triggered because it was off. Administrator stated the Housekeeping [NAME] #1 provided them with a statement and after they reviewed the video surveillance, the Housekeeping [NAME] #1 provided a second statement of what really happened. Administrator stated the incident on 12/31/2025 the Security Guard #1 did not follow the facility policy protocol that if anyone exiting the facility, they should find out if it is a resident or visitor before exiting and they must sign out prior leaving the facility. The Administrator stated when they reviewed the video surveillance, they observed Security Guard #1 allowed Resident #1 to exit the facility without asking them and did not report to Registered Nurse Supervisor #3 of the incident. The Administrator stated they have lists of residents with pictures at risk for elopement posted at the front desk. Security Guard #1 was suspended and reported to their agency. 10New York Codes, Rules, and Regulations 415.12(h)(2)</p>		