

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/12/2026
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)		
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 record review and interviews, the facility failed to ensure that a resident was free from physical restraints. This was evident in one (Resident #52) of three residents reviewed for abuse out of 35 total sampled residents. Specifically, on 09/26/2024, Resident #52 was observed by the staff with their hand mitten tied to the bed side rail. Refer to F609 - Reporting of Alleged Violations. The findings include: The facility's Physical Restraint-Free Care policy dated 05/2026 stated the use of physical restraint shall be considered only when clinically justified to address a specific assessed medical symptom. It should never be used for staff convenience and behavior management. The policy defined restraint as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot move easily and restricts freedom of movement or normal access to the resident's body. Resident #52 had diagnoses that included chronic respiratory failure, ventilator dependent with a tracheostomy tube, Parkinsonism, seizure disorder, restlessness and agitation. The Minimum Data Set (a resident assessment tool) assessment dated [DATE] documented that Resident #52 had severe cognitive impairment. A review of interdisciplinary progress notes from 08/19/2024 through 08/31/2024 revealed that Resident #52 has history of restlessness and kept holding the tracheostomy tubing with their left hand. Left hand mitten was applied as ordered to prevent decannulation. A care plan for the use of hand mitten was initiated on 08/19/2024 with interventions to remove every two hours for 15 minutes for skin check. A review of the Accident/Incident Report dated 10/03/2024 documented that on 09/26/2024 the resident's family reported observing Resident #52's left hand mitten tied to the bed side rail. The facility's internal investigation documented that Registered Nurse #3 immediately untied the resident's hand mitten and assessed the resident for injury of which there was none noted. The nursing supervisor was immediately notified of the incident and also assessed the resident with no injury. A review of Registered Nurse #3's written statement documented they were summoned to Resident #52's bedside by the family at approximately 11:00 AM and observed the resident's left hand mitten attached to the side rail. The Registered Nurse immediately released the tie and did a thorough physical assessment; no injury was noted. The nursing supervisor was immediately notified and came to the bedside. The resident was reassessed throughout the shift and no delayed injury has been noted. During an interview on 06/09/2026 at approximately 12:05 PM, Registered Nurse #3 stated they could not remember the exact date, at around 11:00 AM while administering medication to another resident, Resident #52's family reported the resident's mitten was tied to the bed rail. Registered Nurse #3 stated they observed Resident #52 who was wearing a left hand mitten with the string tied to the side rail of the bed. They stated they immediately released the ties, removed the hand mitten, and did an assessment of the skin, circulation, and range of motion. They stated they notified the nursing supervisor. During an interview on 06/10/2026 approximately 11:00 AM, the Director of Nursing stated that on 10/03/2024, they were informed that Resident #52's next of kin reported during an interdisciplinary meeting that the resident's left hand mitten was tied to the side of the bed. The resident was assessed and nursing staff were re-educated on restraints. The Director of Nursing (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	stated they investigated the incident and concluded no abuse or neglect had occurred. During an interview on 06/11/2026 at approximately 10:16 AM, the Administrator stated they were not aware of the alleged incident that Resident #52's left hand mitten was tied to the bed rail. 10 New York Codes, Rules and Regulations 415.3(d)(1)(vii)		

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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 abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, including to the State Survey Agency. This was evident in two (Residents #52 and #75) of five residents reviewed for abuse and accidents out of 35 total sampled residents. Specifically, 1.) On 09/26/2024, Resident #52 was observed by a licensed nurse with the hand mitten tied to the bedrail restricting the resident's movement. This alleged violation was not reported immediately to the Administrator. In addition, this alleged violation was not reported to the New York State Department of Health within the required timeframe. 2.) On 05/01/2026, Resident #75's family reported that a staff allegedly hit Resident #75 on the face. This facility failed to report this abuse allegation to the New York State Department of Health within the required timeframe. Refer to F604 - Right to be Free from Physical Restraints Refer to F656 - Develop/Implement Comprehensive Care Plan The findings include: The facility's Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Property Policy, reviewed May 2026, required all allegations involving abuse or resulting in serious bodily injury to be reported immediately, but no later than two hours after the allegation was made, to the Administrator and the appropriate state agency; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Resident #52 had diagnoses that included chronic respiratory failure, ventilator dependent with a tracheostomy tube, restlessness, and agitation. The Minimum Data Set (a resident assessment tool) assessment dated [DATE] documented that Resident #52 had severe cognitive impairment. The facility's Accident/Incident Report dated 10/03/2024 documented, on 09/26/2024 at 11:00 AM, the resident's family reported that Resident #52's left hand mitten had been tied to the bed side rail. The licensed staff's written statement documented that the resident's family approached them and reported that the resident's left hand mitten was tied to the bed siderail. They immediately released the tie and did a thorough physical assessment and no injury was noted. The Registered Nurse Supervisor was immediately notified. During an interview on 06/10/2026 at approximately 11:00 AM, the Director of Nursing stated the incident occurred on 09/26/2024 and was not reported to the Director of Nursing or the Administrator when it occurred. The Director of Nursing stated the nurse supervisor addressed the concern with an assessment and staff in-service but did not elevate the allegation to the Director of Nursing or the Administrator. During an interview on 06/11/2026 at approximately 10:16 AM, the Administrator stated allegations of (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse are required to be reported immediately to the Director of Nursing and Administrator for reporting to the Department of Health. The Administrator stated they were not aware of Resident #52's allegation. 2. Resident #75 had diagnoses that included cerebrovascular accident with left hemiplegia and hemiparesis (paralysis and weakness of the left extremities), diabetes mellitus, and major depressive disorder. The Minimum Data Set assessment dated [DATE] documented that Resident #75 was cognitively intact, required maximal assistance for bathing, dressing and mobility, and was dependent on transfers. The facility's incident report documented on 05/04/2026, the Director of Social Service received an email from Resident #75's family member reporting that the resident alleged being struck in the face by a nursing assistant on 05/01/2026. The facility initiated an abuse investigation on 05/04/2026 and concluded there was no evidence of abuse, neglect, or mistreatment. The nursing home investigative report documented that the facility staff was made aware of the incident on 05/04/2026 at 10:45 AM. The alleged abuse was submitted to the New York State Department of Health on 05/04/2026 at 6:24 PM. During an interview on 06/09/2026 at 12:30 PM, the Director of Social Service stated the email reporting that the allegation was received on 05/01/2026 but was not reviewed until 05/04/2026 to which they telephoned the resident's son at 10:49 AM. The resident was also contacted, and Director of Nursing was notified. During an interview on 06/10/2026 at 3:57 PM, the Director of Nursing stated the allegation was not reported within two hours because they believed allegations that could not be substantiated could be reported within 24 hours. They stated they received the report on the morning of 05/24/2026 and completed the investigation on the same day and found no evidence of abuse. They stated they reported the incident that same evening to the New York State Department of Health. During an interview on 06/10/2026 at 3:15 PM, the Administrator stated allegations of abuse are required to be reported to the New York State Department of Health within two hours and acknowledged the allegation involving Resident #75 was not reported within the required timeframe. 10 New York Codes, Rules and Regulations 415.4		

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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 interview, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented to address the resident's medical, physical, mental, and psychosocial needs. This was evident in one (Resident # 75) of three residents reviewed for abuse out of 35 total sampled residents. Specifically, following Resident #75's allegation of abuse reported on 05/04/2026, the facility failed to develop and implement an abuse related care plan until 06/01/2026. The findings include: The facility's Care Planning policy, dated May 2026, required individualized, person-centered care plans to be developed, implemented, reviewed, and revised whenever a resident's condition, risks, or identified problems changed. The policy further required event-driven care plan updates to be completed as soon as practicable, ordinarily within 48 hours, following allegations, investigations, or findings involving abuse, neglect, mistreatment, exploitation, or misappropriation of property. Resident #75 had diagnoses that included cerebrovascular accident with left hemiplegia and hemiparesis (paralysis and weakness of the left extremities), diabetes mellitus, and major depressive disorder. The Minimum Data Set assessment dated [DATE] documented that Resident #75 was cognitively intact, required maximal assistance for bathing, dressing and mobility, and was dependent on transfers. The facility's incident report documented that on 05/04/2026, the Director of Social Service received an email from Resident #75's family member reporting that the resident alleged being struck in the face by a nursing assistant on 05/01/2026. The facility initiated an abuse investigation on 05/04/2026 and concluded there was no evidence of abuse, neglect, or mistreatment. A review of the resident's care plan revealed an Abuse/Neglect care plan was not initiated until 06/01/2026. The care plan documented No Reports of Abuse/Neglect and contained no goals or interventions addressing the abuse allegation or investigation initiated on 05/04/2026. During an interview on 06/08/2026 at 12:06 PM, Resident #75's family member stated the resident telephoned them on 05/01/2026 and reported being hit on the right side of the face but gave no additional details. The family member stated they notified the Social Worker by email that day and was later informed the allegation could not be substantiated, although the staff member was removed from the resident's assignment. During an interview on 06/10/2026 at 10:33 AM, Resident #75 stated a nursing assistant hit them on the right side of the face and shoulder after the resident was unable to turn during morning care. The resident stated they cried for help, no one responded, and they subsequently called their son to report. During an interview on 06/10/2026 at 4:58 PM, Registered Nurse #7, the nursing supervisor, stated abuse care plans are initiated when an allegation of abuse is reported. Registered Nurse #7 further stated the abuse care plan for Resident #75 should have been initiated when the allegation was reported on 05/04/2026 and stated the delay until 06/01/2026 was an oversight. During an interview on 06/10/2026 at 3:57 PM, the Director of Nursing stated the abuse care plan should have been initiated at the time of the allegation and investigation on 05/04/2026 with appropriate goals and interventions. The Director of Nursing further stated the nursing supervisor should have initiated the abuse care plan, and the Assistant Director of Nursing should have ensured the care plan was initiated. 10 New York Codes, Rules and Regulations 415.11(c)(1)		