

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

Printed: 10/09/2026
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 record review and interviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services necessary to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, Specifically, 1.) Residents reported the facility was short staffed of Certified Nursing Assistants which resulted in lack of timely staff response to residents who needed assistance, 2.) Multiple nursing staff members reported lack of sufficient staffing, 3.) Facility's staffing levels were repeatedly below facility assessed levels, and 4.) Excessively low weekend staffing was triggered in the Payroll Based Journal Staffing Data Report for Quarter 2 2026 (January 1 - March 31). The findings include but are not limited to: The Payroll Based Journal Staffing Data Report for Quarter 2 of 2026 (January 1 - March 31) identified the facility as having Excessively Low Weekend Staffing based on submitted weekend staffing data. The facility's Nursing Department Staffing Policy dated 01/2026 required sufficient nursing staff to provide care in accordance with physician orders, resident care plans, federal and state regulations and facility policy. The policy established minimum licensed nurse staffing of one Registered Nurse or Licensed Practical Nurse per shift on Units 2, 3, 4, 6, and 7; and two licensed nurses per shift on Unit 5 which was a ventilator unit. The policy further established minimum certified nursing assistant staffing as follows: Units 2, 3, 4, 6, and 7: five on the day shift, three on the evening, and two on the night shift Unit 5: six on the day shift, four on the evening, and four on the night shift The facility assessment, last updated on 05/29/2026, documented a licensed bed capacity of 240 and an average daily census of 228. The assessment identified required staffing for a 24-hour period as follows: Units 2, 3, 4, 6, and 7: three licensed nurses and 10 certified nursing assistants per unit Unit 5: six nurses and 14 certified nursing assistants The assessment specified that weekend staffing was to remain at the same levels. Review of the actual weekend facility staffing schedule by units and shift from 01/02/2026-03/28/2026 revealed the following staff shortages: 01/02/2026 -11:00PM-7:00AM shift - shortage of one Certified Nursing Assistant. 01/03/2026-7:00AM-3:00PM shift - shortage of 10 Certified Nursing Assistants. 01/04/2026-7:00AM-3:00PM shift - shortage of eight Certified Nursing Assistants. 01/04/2026 3:00pm-11:00PM shift - shortage of one Certified Nursing Assistants. 01/10/2026 7:00AM-3:00PM shift - shortage of seven Certified Nursing Assistants. 01/11/2026 7:00AM-3:00PM shift - shortage of nine Certified Nursing Assistants. 01/11/2026 3:00pm-11:00PM shift - shortage of one Certified Nursing Assistant. 01/11/2026 11:00PM-7:00AM shift - shortage of one Certified Nursing Assistant. 01/16/2026 11:00PM-7:00AM shift - shortage of one Certified Nursing Assistant. 01/17/2026 7:00AM-3:00PM shift - shortage of eight Certified Nursing Assistants. 01/17/2026 3:00pm-11:00PM shift - shortage of one Certified Nursing Assistant. 01/17/2026 11:00PM-7:00AM shift - shortage of one Certified Nursing Assistant. 01/18/2026 7:00AM-3:00PM shift - shortage of seven Certified Nursing Assistants. (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 - Many	par level for certified nursing assistants for the 7:00 AM - 3:00 PM shift is 5, but they are staffed usually with four resulting in longer wait times for the residents to receive assistance. During an interview on 06/11/2026 at 3:47 PM, Licensed Practical Nurse #2 stated the 3:00 PM to 11:00 PM shift is usually staffed with three nursing assistants, but if one calls out and no replacement is available, the assignments are divided amongst the remaining staff. During an interview on 06/11/2026 at 11:51 AM, the Staffing Coordinator stated staffing schedules are prepared monthly using full-time, part-time, per diem, and agency staff based on the staffing policy and facility assessment. Weekend coverage is challenging due to staff availability, religious observances, and second jobs. They stated weekend call-outs are managed by the Registered Nurse Supervisors using staff availability lists. During an interview on 06/12/2026 at 1:05 PM, the Director of Nursing stated staffing par levels have increased and are monitored through the Quality Assurance process. They stated overtime incentives, per diem staff, and agency personnel are used to address shortages, and schedules are prepared in advance to maintain established staffing levels. During an interview on 06/11/2026 at 12:14 PM, the Administrator stated they were aware of the Payroll Based Journal staffing trigger. They stated weekend staffing remains challenging due to competition with other facilities. They stated the facility continues to recruit nurses and certified nursing assistants directly while reducing agency use to improve retention. 10 New York Code Rules and Regulations 415.13(a)(1) (i-iii)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the resident representative was notified of an accident involving the resident which results in injury and has the potential for requiring physician intervention. This was evident in one of one resident (Resident #25) reviewed for notification of change out of 38 total sampled residents. Specifically, the facility failed to notify Resident #25's representative of the resident's fall with injury on 03/23/2026. The findings include: The Facility's Policy titled Family/Responsible Party Notification of Change in Condition and Hospital Transfer, last reviewed on 05/2026, requires timely notification of a resident's representative following accidents or injuries. The policy further requires that unsuccessful notification attempts must be documented and that all notifications or attempted notifications be recorded in the medical record. Resident #25 was admitted with diagnoses of stroke, lung cancer, and brain cancer. admission Minimum Data Set assessment dated [DATE] documented the resident was severely cognitively impaired, sustained a fall with injury since admission, and that only the representative participated in the assessment. The facility's resident matrix also identified Resident #25 as having sustained a fall with injury. A review of the progress note dated 03/23/2026 by Registered Nurse #1, documented that Resident #25 fell at 12:50 AM and sustained a 0.3-centimeter laceration to the left eyebrow with minimal bleeding. The note stated there was no emergency contact phone number available and that the Social Worker would be notified to follow up with the resident's representative. There was no documentation in the medical record that the representative was notified or that notification attempts were made. During an interview on 06/07/2026 at 11:13 AM, Resident #25's designated representative stated they were never notified of the fall or resulting injury and first became aware of the incident during the survey. The representative stated the facility routinely contacted them and had their telephone number. A record review showed the resident's initial face sheet dated 03/18/2026 did not include emergency contact information. An updated face sheet dated 03/24/2026 listed the designated representative as the primary emergency contact, including a telephone number and email address. During an interview on 06/11/2026 at 8:33 AM, Registered Nurse #1 stated there was no emergency contact information available at the time of the incident and that they verbally requested Social Worker #1 and Registered Nurse #2, who was the day shift nursing supervisor, to follow up with notification. During an interview on 06/10/2026 at 11:02 AM, Registered Nurse #2 stated the resident's representative was actively involved in the resident's care and could be reached by telephone but did not recall being asked to notify the representative. During an interview on 06/11/2026 at 9:22 AM, Social Worker #1 stated they obtained the representative's contact information on 03/24/2026 while addressing advance directives and discharge planning and updated the face sheet accordingly. Social Worker #1 further stated they were unaware Resident #25 had fallen on 03/23/2026 and were never asked to notify the representative. During an interview on 06/10/2026 at 11:59 AM, the Director of Nursing stated the nurse supervisor is responsible for notifying the resident's representative following an incident, documenting notification attempts, and ensuring follow-up with Admissions Office if emergency contact information is unavailable. The Director of Nursing was unable to explain why Resident #25's representative was not notified of the fall with injury on 03/23/2026. 10 New York Code, Rules and Regulations 415.3(e)(2)(ii)(b)		

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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 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 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)		

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 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on observation, record review, and interview, the facility failed to ensure quarterly Minimum Data Set assessments were completed within the required timeframe. This was evident in three (Residents #23, #59, and #225) of 13 residents reviewed for resident assessment. Specifically, the quarterly Minimum Data Set assessments were not completed within 14 days of the Assessment Reference Date. The findings include: The facility's policy and procedure dated 05/2026 titled Resident Assessment Instrument, Minimum Data Set, Care Area Assessment, Care Planning, Transmission, and Quality Assurance Policy required all Minimum Data Set assessments to be completed and transmitted in accordance with the timeframes established in the Centers for Medicare and Medicaid Services Resident Assessment Instrument Manual. Resident #23's quarterly Minimum Data Set assessment with a reference date of 05/21/2025 was completed on 06/10/2025. The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented Resident #23's Minimum Data Set assessment was completed late, more than 14 days after the assessment reference date. Resident #59's quarterly Minimum Data Set Assessment with a reference date of 03/14/2026 was completed on 05/07/2026. The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented Resident #59's Minimum Data Set assessment was completed late, more than 14 days after the assessment reference date. Resident #225's quarterly Minimum Data Set Assessment with a reference date of 02/10/2025 was completed on 03/11/2025. The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented Resident #59's Minimum Data Set assessment was completed late, more than 14 days after the assessment reference date. During an interview on 06/12/2026 at approximately 10:10 AM, the Minimum Data Set Director acknowledged the quarterly Minimum Data Set assessments were not completed timely and stated the delays occurred because they were working alone. 10 New York Codes, Rules and Regulations 415.11(a)(4)		

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

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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	
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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 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 observation, record review, and interview, the facility failed to ensure Minimum Data Set assessments were electronically transmitted to the Centers of Medicare/Medicaid Services Data System within 14 days after assessments were completed. This was evident in two (Residents #98 and #149) of 13 residents reviewed for timely Minimum Data Set transmission. Specifically, quarterly [NAME] Data Set assessments for Residents #98 and #149 were submitted after the required timeframe. The findings include: The facility's policy and procedure dated 05/2026 titled Resident Assessment Instrument, Minimum Data Set, Care Area Assessment, Care Planning, Transmission, and Quality Assurance Policy required all Minimum Data Set assessments to be completed, electronically transmitted, and accepted by Centers for Medicare and Medicaid Services no later than 14 days after the Minimum Data Set completion date. The policy required compliance with CMS transmission deadlines for all required assessments. Resident #98's Quarterly Minimum Data Set assessment was completed on 05/20/2026 and was transmitted to the Centers for Medicare and Medicaid Services Data System on 06/04/2026. Resident #149's Quarterly Minimum Data Set assessment was completed on 05/26/2025 and was transmitted to the Centers for Medicare and Medicaid Services Data System on 06/10/2025. A second Quarterly Minimum Data Set assessment was completed for Resident #149 on 11/26/2025 and was transmitted to the Centers for Medicare and Medicaid Services Data System on 01/02/2026. A third Quarterly Minimum Data Set assessment was completed for Resident #149 on 05/12/2026 and was transmitted to the Centers for Medicare and Medicaid Services Data System on 06/03/2026. During an interview on 06/12/2026 at approximately 10:10 AM, the Minimum Data Set Director acknowledged the quarterly Minimum Data Set assessments were submitted late and stated the delays occurred because they were working alone. 10 New York Codes, Rules and Regulation 415.11		

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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	
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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the Minimum Data Set assessments accurately reflected residents' clinical status. This was evident in two (Residents #21 and #29) of 38 total sampled residents. Specifically, The Minimum Data Set assessment inaccurately documented internal bleeding for Resident #21, and failed to identify an indwelling urinary catheter for Resident #29. The findings include: A review of the facility's policy titled Resident Assessment Instrument, Minimum Data Set, Care Are Assessment, Care Planning, Transmission, and Quality Assurance Policy', last revised on 05/2026, required the facility to complete accurate resident assessments in accordance with Centers for Medicare & Medicaid Services requirements. 1) Resident #21 had diagnoses of dementia, anemia, and pulmonary embolism. The Annual Minimum Data Set assessment dated [DATE] documented Resident #21 was receiving anticoagulant therapy and had internal bleeding. The physician orders dated 10/31/2025 documented Xarelto 10 milligrams daily and Aspirin at 81 milligrams daily. There was no documentation supporting that Resident #21 experienced internal bleeding. During an interview on 06/10/2026 at 11:18 AM, Registered Nurse #2 stated there was no documentation or report that Resident #21 had abnormal or internal bleeding. During an interview on 06/10/2026 at 1:19 PM, Minimum Data Set Assessor #1 stated they documented internal bleeding in error. During an interview on 06/10/2026 at 1:22 PM, the Minimum Data Set Director stated the Minimum Data Set was coded incorrectly and confirmed the documentation of internal bleeding was an error. 2. Resident #29 had diagnoses that included urinary retention, benign prostatic hyperplasia, obstructive and reflux uropathy. A nurse admission progress note dated 04/22/2026 documented Resident #29 was readmitted to the facility with a foley catheter attached to a drainage bag. A care plan for indwelling urinary catheter was initiated on 04/22/2026. The Comprehensive Minimum Data Set assessment dated [DATE] did not identify the resident as having an indwelling urinary catheter. Section H0100A, Bladder and Bowel, was left blank. During an interview on 06/11/2026 at approximately 10:44 AM, Minimum Data Set Assessor #2 stated the information entered into Resident #29's Minimum Data Set was intended for another resident and (continued on next page)		

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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	
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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	acknowledged that the assessment was completed in error. During an interview conducted on 06/11/2026 at approximately 10:39 AM, Minimum Data Set Director stated Resident #29's Minimum Data Set assessment should have been coded to reflect an indwelling urinary catheter. They acknowledged responsibility for ensuring the accuracy of completed assessments. 10 New York Codes, Rules and Regulations 415.11(b)		