STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505074	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor Rehabilitation Ctr	1710 Plaza Way Walla Walla, WA 99362

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to implement their abuse prohibition policy/procedures to identify, investigate, and report allegations of abuse/neglect for 5 of 8 residents (Residents 82, 71, 4, 33, and 77) reviewed for grievances. This failure placed the residents at risk of continued abuse/neglect, emotional distress, feeling unsafe, loss of dignity and unmet care needs. Findings included. Review of the facility policy titled, Abuse Prevention and Reporting, revised 10/2025, showed residents had the right to be free from abuse, including the failure to provide basic care/services, physical, verbal, and mental abuse. The policy showed all suspected allegations would be thoroughly and completely investigated and reported to the State Agency (SA). Resident 82 Review of the medical record showed Resident 82 was admitted to the facility with diagnoses including chronic kidney disease (a long-term condition where the kidneys are damaged and lose their ability to filter waste and excess fluid from the blood). Review of the 04/07/2026 comprehensive assessment showed Resident 82 was cognitively intact and required the assistance of one staff member with activities of daily living (ADLs). Review of a facility grievance form dated 01/06/2026, showed Resident 82 stated a Nursing Assistant, (NA), was rough during a brief change. The grievance showed Resident 82 stated they told the NA they did not need to be so rough during their care and did not want them to provide further care for them. Further review showed despite the allegation of abuse, the facility did not escalate the grievance and report to the SA. During an interview on 05/15/2026 at 9:15 AM, Resident 82 stated an NA, came in to change their brief during the night shift and was rough. The resident stated they reported the incident and it felt like they were trying to clean a toilet or something, it really hurt. Resident 71 Review of the medical record showed Resident 71 was admitted to the facility with diagnoses including myocardial infarction (a lack of oxygen to the heart that causes damage or death to the heart), diabetes (excess sugar in the blood) and obstructive sleep apnea (OSA-a sleep disorder with breathing interruptions that causes airway blockage). Review of the 10/21/2025 comprehensive assessment showed Resident 71 required the assistance of one to two staff members for ADLs and had an intact cognition. Review of a facility grievance form dated 11/04/2025, showed Resident 71 felt the NA was rude, (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hurried and did not provide care in a personal manner. The grievance showed Resident 71 stated the NA nearly took their lips off, when the NA placed their OSA mask on, and they requested the NA not provide any additional care for them. There was no record of a facility investigation or report made to the SA, regarding the allegation of abuse. During an interview on 05/14/2026 at 1:49 PM, Resident 71 stated the incident with the NA was rushed and felt they did not want to provide any cares for them. Resident 71 stated they did not know a grievance form was completed and did not state the NA needed customer service training. Resident 71 stated they received no response from the facility. Resident 4 Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including heart failure, diabetes, and a stroke (a medical emergency that occurs when blood flow the brain is disrupted and deprives the brain of oxygen, leading to brain damage, disability or death). Review of the 11/24/2025 comprehensive assessment showed Resident 4 was dependent on one to two staff members for ADLs, including eating, and had an intact cognition. Review of a facility grievance form dated 12/05/2025 showed Resident 4 was being assisted during a meal when the NA shoveled food into their mouth and they felt they were choking. Resident 4 did not want the NA to provide cares for them. Further review of the grievance showed Resident 4 did not like the NA and the NA would complete a training module on customer service. There was no record of a facility investigation or report to SA regarding the allegation of abuse. Resident 33 Review of the medical record showed Resident 33 was admitted to the facility with diagnoses including pneumonia (a respiratory virus infecting the lungs making it hard to breathe), heart failure and malnutrition. Review of the 01/27/2026 comprehensive assessment showed Resident 33 required the assistance of one to two staff members for ADLs and had a moderately impaired cognition. Review of the facility grievance form dated 01/28/2026 showed Resident 33 needed to use the restroom and was told by an NA you literally went 15 minutes ago; can you hold it? The grievance showed Resident 33 said they could not and the NA reluctantly assisted them. Resident 33 felt they should not have been questioned when they needed to use the restroom. Further reviews showed there was no facility investigation or report made to the SA after the allegation of abuse. Resident 77 Review of the medical record showed Resident 77 was admitted to the facility with diagnoses including a displaced fracture of the left hip and aftercare for a left hip replacement surgery. Review of the 04/17/2026 comprehensive assessment showed they were cognitively intact and required assistance from one to two staff members to transfer from one seated or lying position to another. Review of Resident 77's admission physician orders dated 04/15/2026 showed not to bend the hip past 90 degrees, cross the leg, turn on the left foot, or point the toes inward to prevent dislocation. Review of a facility grievance form dated 04/17/2026, showed Resident 77 had requested assistance to use the bathroom around dinnertime on 04/15/2026. The NA that assisted Resident 77 rushed them (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the bathroom, grabbed the left surgical hip area and caused Resident 77 to yell out and was too rough. Resident 77 stated the NA would not listen when they told the NA they were hurting them. Further review of the grievance form showed no facility investigation or report made to the SA after the allegation of abuse. During an interview on 05/13/2026 at 4:59 PM, Resident 77 stated the NA seemed rushed and wasn't moving them correctly causing them so much pain that they yelled out for the NA to stop. Resident 77 stated the NA would not listen to them and continued to manhandle them to the toilet. Resident 77 stated they were frightened the NA was going to dislocate their newly fixed hip. Resident 77 stated they reported to the facility because the NA had hurt them and believed if the NA did that to them, they must be doing it to others and wanted to ensure the staff were aware and watchful of the NA. Further review of the grievance form showed the facility did not escalate the grievance regarding an allegation of abuse and perform a thorough investigation and report to the SA. During an interview on 05/14/2026 at 3:02 PM, Staff C, Social Services Director, stated the grievance process was when a resident had a complaint the resident would be provided a grievance form to fill out, or the facility would complete one for the resident. Staff C stated depending on the reported concern/complaint, they would proceed with additional questions to the residents and when needed escalate to the department head for the complaint. Staff C stated when the grievance was more than rude staff member, they would ensure the Assistant Director of Nursing or Director of Nursing was made aware. Staff C stated when the facility did not believe the grievance to be an allegation of abuse, they would still need to report to the SA and complete an investigation. During an interview on 05/14/2026 at 3:30 PM, Staff B, Director of Nursing, stated when grievances were about abuse/neglect they would be made aware. Staff B stated grievances regarding resident concerns with rough care or rude statements made by staff to the residents could be abuse or neglect. Staff B stated they would discuss the concern with Staff A, Administrator and Staff C, ensure the residents were safe, suspend the staff member, complete a facility investigation and report to SA. Staff B stated this process was not followed for the allegations of abuse and neglect. During an interview on 05/14/2026 at 3:58 PM, Staff A stated the grievances could be allegations of abuse/neglect and the facility should have escalated the incidents, fully investigated them, and reported to the SA. Staff A stated the facility abuse prohibition policy was not followed. Reference WAC: 388-97-0640(1)(2)(b)(3)(a)(c)(5)(6)(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the food was palatable and served at a safe and appetizing temperature and in a timely manner for 6 of 9 residents (Residents 51, 19, 4, 55, 45 and 19) reviewed for food. This failure placed residents at risk for food-borne illness, dissatisfaction with meals, and inadequate nutritional intake. Findings included.Review of the Washington State Food Code, dated 03/01/2022, showed long-term care facilities must comply with the food code for temperature control, while meeting specific resident care requirements. Facilities must provide nourishing, palatable meals that were attractively served and adjusted to residents' preferences and needs. Further review showed food must be held at 135 degrees Fahrenheit (F-unit of measure) or above for hot holding or below 41 degrees F for cold holding, minimizing time in the dangerous zone (the temperature range where harmful bacteria multiply fastest on perishable foods) of 41 degrees F to 135 degrees F. Resident 51 Review of the medical record showed Resident 51 was admitted to the facility with diagnoses including a right below the knee amputation and diabetes (excess sugar in the blood). The 02/17/2026 comprehensive assessment showed Resident 51 required the assistance of one to two staff for activities of daily living (ADLs-activities related to personal care) and had an intact cognition. Resident 19 Review of the medical record showed Resident 19 was admitted to the facility with diagnoses including heart and kidney disease. The 03/11/2026 comprehensive assessment showed Resident 19 required the assistance of one to two staff for ADLs and had intact cognition. Resident 4 Review of the medical record showed Resident 4 was admitted to the facility with diagnoses to include diabetes and eating difficulties. Review of the comprehensive assessment dated [DATE], showed the resident was dependent on a staff member to assist with meals and their cognition was intact. Resident 55 Review of the medical record showed Resident 55 was admitted to the facility with diagnoses including Parkinson's disease (a progressive movement disorder that causes tremors, stiffness and impaired balance) and anemia (a deficiency in red blood cells). Review of the 04/20/2026 comprehensive assessment showed Resident 55 was independent for eating and had intact cognition. Resident 45 Review of the medical record showed Resident 45 was admitted to the facility with diagnoses including heart failure, kidney disease and chronic pain. Review of the 02/11/2026 comprehensive assessment showed Resident 45 required set-up assistance of one staff member for eating and had an intact cognition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 71 Review of the medical record showed Resident 71 was admitted to the facility with diagnoses including myocardial infarction (a lack of oxygen to the heart that causes damage or death to the heart) and diabetes. Review of the 10/21/2025 comprehensive assessment showed Resident 71 required the assistance of one to two staff members for ADLs and had an intact cognition. During a resident council meeting (a formally organized, independent group of residents who meet regularly to advocate for their rights, voice concerns, and plan activities) on 05/12/2026 at 1:33 PM, Resident 51 stated their food was consistently cold when served to them in their room, located on the west hall of the facility. They stated their meals were always cold because the west hall was the last to be served from the kitchen. Resident 51 stated there were scheduled mealtimes, but the times they actually received their meals varied greatly. At 1:40 PM, Resident 19 stated the meals were always cold by the time the west hall received their trays. Resident 19 stated it didn't seem fair that the south hall and south dining room of the facility always got their meals served fresh and hot from the kitchen while the west hall was always served last. They stated their food was consistently served cold. During an interview on 05/11/2026 at 11:32 AM, Resident 55 stated their food was lukewarm at best. Resident 55 stated they were last to be served, as their room was at the end of the west hall. Resident 55 stated the meal serve out times were varied and not consistent. During an interview on 05/11/2026 at 12:06 PM, Resident 45 stated their meals were served late, the food was cold, and the facility was aware of the problem. During an observation on 05/11/2026 at 12:24 PM, showed the meal cart was delivered to the west hall. At 12:46 PM, the last meal tray was delivered to the residents, 22 minutes after the meal cart was delivered to the west hall. The meal cart was a non-insulated steel cart with doors accessible on both sides of the cart and were not shut completely after each meal tray was obtained. During an interview on 05/11/2026 at 3:15 PM, Resident 4 stated the steak served was so tough, they could not chew it, the food was served cold and was just not fit to eat. During a concurrent observation and interview on 05/13/2026 at 11:17 AM, Staff E, Cook, observed the kitchen staff serve out the lunch meal. They stated they took food temperatures when they were plating the food and documented them on a form used in the kitchen but did not check the temperatures again after the residents were served. During an observation on 05/13/2026 at 12:32 PM, showed the first meal cart was delivered to the west hall and delivery was completed at 12:43 PM. The second meal cart was delivered to the west hall at 12:48 PM. The meal cart doors were not shut completely after each meal tray was obtained. Observation of test trays requested on 05/13/2026 at 12:32 PM, showed Staff E used an oven safe dial thermometer when they obtained the temperatures of the test trays prior to leaving the kitchen. The temperatures were as follows: chicken patty temperature of 140 degrees F, rice pilaf of 125 degrees F, steamed mixed vegetables at 136 degrees F, and the alternative meal, the haystack (loose lettuce with chili and corn chips) at 125 degrees F. At 12:46 PM, Staff D, Dietary Supervisor, obtained the temperatures of the test trays once all resident trays were served. Staff D used an oven safe dial thermometer and obtained the following temperatures: chicken patty temperature of 110 degrees F, (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rice pilaf of 105 degrees F, steamed mixed vegetables of 110 degrees F, and the haystack of 99 degrees F. Staff D stated they did not understand how the food temperatures could have dropped so much, as the food was steaming when plated. They stated the temperatures must be off. During an interview on 05/13/2026 at 12:39 PM, Resident 51 stated they ate their lunch in the North dining room because they get their lunch an hour earlier than when they had lunch in their room and they did not want to wait to eat later or have cold food. During a taste testing of the test tray by the surveyors on 05/13/2026 at 12:56 PM, the chicken patty was cold in the center and had a bland, rubbery and freezer-burned aftertaste to it. The rice pilaf was cold, plain and stale (lacked freshness), the vegetables were cold and bland, and the alternative meal, the haystack, had canned chili beans on it that were cold to eat. During on observation on 05/13/2026 at 5:11 PM, showed the south hall meal cart had been delivered and the last meal tray was being served. At 6:01 PM, the west hall meal cart had been delivered, 50 minutes after the south hall residents were served. During an interview on 05/14/2026 at 1:49 PM, Resident 71 stated the food was cold, unappealing, and tasted like cardboard. Resident 71 stated meals were served at inconsistent times, despite the scheduled times for meals. During an interview on 05/15/2026 at 8:32 AM, Staff A, Administrator stated they were aware of the inconsistent food temperatures and would be discussing it with the team to find a better process. Staff A stated they do have some things to fix. Reference: WAC 388-97-1100(1)(2)