STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525612	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor Ltd	250 Lawrence Ave Park Falls, WI 54552

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 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 Interview and record review, the facility did not ensure that all alleged violations involving abuse resulting in physical harm, pain or mental anguish are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility (including to the State Survey Agency) and to other officials in accordance with State law through established procedures for 2 (R5, R8) of 6 residents. On 4/16/26 at 8:15 AM, R6 barricaded self in R5's room and threatened to harm R5. The facility did not report this within allotted time frames. On 6/4/25 at approximately 7:40 AM, Certified Nursing Assistant (CNA) D heard Registered Nurse (RN) E yelling at R8. This was not reported within allotted time frames.Findings include The facility policy titled Abuse and Misconduct last reviewed on 05/01/26, states under the section labeled Abuse .definitions, states: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in .mental anguish. The policy further defines mental abuse as the issue of verbal or nonverbal conduct which causes, or has the potential to cause, the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Example 1 On 05/06/26, Surveyor reviewed R6's medical record. R6 was admitted to facility on 03/19/2026 with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, R6's Minimum Data Set (MDS) assessment dated [DATE] indicated Brief Interview for Mental Status (BIMS) score was 12/15 (mildly impaired) R6's care plan had a problem and approaches with start date of 03/22/2026 of I have a behavior problem related to nursing home placement, with approaches of: *Explain all procedures to me before starting and allow me (5 minutes) to adjust to changes. *If I am safe, allow me my space. *If I pose a potential threat to injure self or others notify providers. S *If I wander or pace, initiate visual supervision during any acute episode. *Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's care plan revised on 04/20/26 states: New behavior potentially causing harm to others, *Physically aggressive, *Poor impulse control, *verbally aggressive. Target behaviors, verbal threat of harm against others. Related to cognitive, impairment, disease process, infection and dementia. R6's medical record revealed on 04/16/26 at 8:15 AM, Social Worker (SW) C, became aware of an abuse allegation between R5 and R6 when staff overheard the argument between R5 and R6, who are husband and wife, in which R6 barricaded self in R5's room and threatened to kill R5. Staff immediately reported to SW C. The verbal abuse caused R5 immediate negative effects of fear, anger and emotional harm. The facility did not report the abuse to the SA (State Agency) within 2 hours of determining abuse occurred within 2 hours of becoming aware of incident/allegation. On 05/06/26 at 12:40 PM, Surveyor interviewed SW C who stated was not aware of need to report allegation of abuse within 2 hours if there was not physical harm. Example 2 On 05/06/26 at 10:15 AM, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE]. On 05/16/25, R8's Minimum Data Set (MDS) assessment noted a score of 99 for Brief Interview for Mental Status (BIMS) due to R8's severe cognitive impairment and inability to complete the assessment. R8's care plan includes a focus of impaired cognitive function or impaired thought process related to developmental delay or disability (initiated on 02/17/25) with interventions of face me when speaking and make eye contact. R8's care plan includes a focus of psychosocial well-being problem.may experience feelings of powerlessness.ineffective coping skills.(initiated on 02/17/25) with interventions including, allow me time to answer questions and to verbalize feelings, perceptions, and fears. R8's care plan includes a focus of vulnerable adult and at risk for potential abuse (initiated on 02/17/25) with interventions including, facility staff will follow policy and procedures and will be provided education on reporting allegations of abuse. R8's nurse's documented on 06/04/25 at 8:07 AM, Certified Nursing Assistant (CNA) D reported to Social Worker C at approximately 7:35-7:40 AM, CNA D heard Registered Nurse (RN) E yelling at someone in the dining room as CNA was walking toward the dining room from the 600 hall. CNA D stated it was clear to CNA D, RN E was upset and verbally aggressive. CNA D stated CNA D asked RN E what was going on. CNA stated RN E told CNA E that R8 was pounding on the table and stated something similar to the act being ridiculous and unnecessary. CNA D stated CNA D told RN E that R8 does this as a form of communication with another resident. CNA D stated R8 was visibly upset after the encounter and kept repeating the encounter. CNA D stated CNA F and Licensed Practical Nurse (LPN) G were present and witnessed the incident. On 05/06/26, Surveyor reviewed R8's medical record regarding the most recent vulnerability assessment completed prior to the incident. The assessment was dated 05/09/25 and indicated R8 was unable to report abuse/neglect concerns. On 05/06/26 at 2:54 PM, Surveyor interviewed SW C about the incident on 06/04/25. SW C acknowledged the event should have been reported within two hours to the police and the SA for verbal abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not complete a thorough investigation regarding potential verbal and psychosocial abuse for 1 of 6 residents reviewed (R8),-The facility did not remove the accused staff member from the facility pending investigation-All present parties to the incident were not interviewed Findings include:On 05/06/26 at 12:15 PM, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE].On 05/16/25, R8's Minimum Data Set (MDS) assessment noted a score of 99 for Brief Interview for Mental Status (BIMS) due to R8's severe cognitive impairment and inability to complete the assessment.R8's care plan includes a focus of impaired cognitive function or impaired thought process related to developmental delay or disability (initiated on 02/17/25) with interventions of face me when speaking and make eye contact. R8's care plan includes a focus of psychosocial well-being problem.may experience feelings of powerlessness.ineffective coping skills.(initiated on 02/17/25) with interventions including, allow me time to answer questions and to verbalize feelings, perceptions, and fears. R8's care plan includes a focus of vulnerable adult and at risk for potential abuse (initiated on 02/17/25) with interventions including, facility staff will follow policy and procedures and will be provided education on reporting allegations of abuse.On 06/04/25 at 8:07 AM, Certified Nursing Assistant (CNA) D reported to Social Worker C that at approximately 7:35-7:40 AM, CNA D heard Registered Nurse (RN) E yelling at someone in the dining room as CNA was walking toward the dining room from the 600 hall. CNA D stated it was clear to CNA D RN E was upset and verbally aggressive. CNA D stated CNA D asked RN E what was going on. CNA D stated that RN E told CNA D R8 was pounding on the table and stated something similar to the act being ridiculous and unnecessary. CNA D stated CNA D told RN E that R8 does that as a form of communication with another resident. CNA D stated R8 was visibly upset after the encounter and kept repeating the encounter. CNA D stated CNA F and Licensed Practical Nurse (LPN) G were present and witnessed the incident.On 06/04/25 at 8:15 AM, SW C began the investigation in relation to allegation of verbal and emotional abuse to R8 which included interviews with staff and residents.On 05/06/26, Surveyor reviewed the most recent vulnerability assessment completed prior to the incident. The assessment was dated 05/09/25 and indicated R8 was unable to report abuse/neglect concerns.RN E is no longer working at the facility and was unavailable for interview.On 05/06/26 at 1:28 PM, Surveyor observed R8 in relation to demeanor. R8 appeared calm and in no distress. R8 was uninterviewable in relation to the incident.On 05/06/26 at 2:54 PM, Surveyor interviewed SW C about the incident on 06/04/25. Surveyor asked SW C about removing RN E from the floor while investigation was pending. SW C indicated RN E was in SW C's office for a short time before being allowed to the floor to continue the shift. Surveyor asked SW C about any education provided to the staff after the incident. SW C stated if there is nothing attached to the investigation, then nothing formal was completed. SW C acknowledged due to R8's severe cognitive impairments and inability to report feelings of fear or other negative effects, the one-hour time frame was not long enough to form a conclusion, and the event should have been investigated further. SW C acknowledged education should have been provided, RN E should have been removed pending further investigation, LPN G should have been interviewed, and the care plan interventions should have been followed in relation to the event.