

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: 525612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Park Manor Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 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 record review and interviews, the facility did not ensure that an alleged violation involving abuse was reported to the State Survey (SA) and law enforcement. This had the potential to affect 1 of 4 residents (R1) investigated for abuse. The facility reported the incident to the SA within five days following their investigation, but did not report the injury of unknown origin to the SA within 24 hours. Surveyor reviewed the facility's policy titled Abuse and Misconduct, which read in part, The administrator, Director of Social Services, and/or the Director of Nursing determined whether the suspicion/alleged incident is reportable (meets the definition of caregiver misconduct) to the Division of Quality Assurance and other officials. On 06/20/26, the facility submitted an alleged nursing home resident mistreatment, neglect, and abuse report to the State Agency (SA). The report stated the following: On Monday, 06/15/26, R1 was noted by nursing staff to have bruising to upper right extremity, measuring 13 cm x 14.5 cm. DON immediately began an Injury of Unknown Origin investigation. Physical Abuse was ruled out and neglect was ruled out. The source of the bruising was determined to occur during a transfer with a mechanical lift. It was determined that this was the appropriate manner of transfer. Primary care physician and family updated. On Friday, 06/19/26, R1 began experiencing pain in the right extremity. Primary care physician was updated, and R1 was sent to the emergency department. Results on the evening of 06/19/26 indicated a humerus fracture of right extremity. Director of Social Services was contacted on 06/20/26 at 9:01 AM. Based on the presence of a significant injury, Director of Social Services reported the incident to the SA on 06/20/26. The facility reported abuse and neglect were ruled out on 06/15/26. The injury of unknown origin investigation conducted on 06/15/26 indicated that it was likely that the injury (bruise) was the result of the mechanical lift. The presence of the fracture on 06/19/2026 and notification of Director of Social Services on 06/20/26 of the fracture indicated that significant injury occurred that is not deemed physical abuse or neglect. On 06/22/26, the facility submitted a Misconduct Incident Report to the SA. The report had the following information: R1 is alert and oriented. They were able to inform staff that no one had caused them any physical injury. R1 was unable to state how the injury happened. The effect on R1 is more than minor in that they suffered serious injury. The injury is not abuse as this was ruled out. The incident meets the definition of injury of unknown origin. R1 is being monitored, and their pain is being treated. R1 continues to state that no one physically harmed them. R1 has pain in their arm, and a reasonable person would conclude that the fractures and associated pain are more than minor. On 07/09/26, Surveyor reviewed R1's record. R1 was admitted to the facility on [DATE], after hospitalization for fractured femur. R1's diagnoses included stroke affecting right side, embolism and thrombosis requiring daily anti-coagulation therapy. R1's most recent Brief Interview for Mental Status confirmed R1 scored 12/15, indicating intact cognition. On 07/09/26, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility's investigation and confirmed the facility did complete staff interviews to determine how the injury may have occurred. R1's primary provider and Power of Attorney (POA) were updated. Staff continued ongoing assessment of R1's injury and reported changes to R1's primary provider. Surveyor determined the facility's investigation was thorough, however the initial report was not submitted within 24 hours of becoming aware of the injury and law enforcement was not updated for reporting suspicion of a crime. On 07/09/26 at 12:30 PM, Surveyor interviewed R2, R3, and R4. These residents reside in the same hall as R1. R2, R3, and R4 did not have concerns related to their care and denied any abuse. On 07/09/26 at 12:44 PM, Surveyor interviewed R1. R1 was lying in their bed and had partially removed the sling from their right arm. Certified Nursing Assistant (CNA) D was present in the room and encouraging R1 to eat. R1 reported they did not know how the injury to their arm occurred but denied anyone at the nursing home had hurt them. R1 stated they are good to me here. On 07/09/26, Surveyor interviewed RN C. RN C reported initially the bruise appeared to maybe have been caused from the blood pressure cuff of the automatic machine. RN C stated when the bruise started to appear larger on 06/18/26, staff considered the bruise may have been caused by the mechanical sit-to-stand. Surveyor and RN C did observe the blood pressure cuff machine and noted to have three sizes of cuffs. Surveyor and RN C observed the mechanical sit-to-stand lift and noted the sling was very thick and the top of the sling rounded, like a pool noodle. RN C reported R1 did not initially report any pain, but on 06/20/26 R1 did report pain, and it was determined to send R1 to the ER at that time. RN C confirmed the staff receive abuse training and denied any abuse occurring in the facility. On 07/09/26 at 1:10 PM, Surveyor interviewed CNA D. CNA D confirmed staff receive abuse training and denied any abuse occurring in the facility. CNA D reported they were called and interviewed after the bruise was noted on R1. CNA D stated they reported the only thing they had done was take R1's blood pressure and was not aware of any other incident occurring. CNA D reported they use the regular size blood pressure cuff on R1. CNA D denied knowing how the injury occurred. On 07/09/26 at 1:24 PM, Surveyor interviewed Director of Nursing in training (DON) E. DON E reported R1's bruise was thought to be caused from the blood pressure cuff, as the bruise appeared in a rectangular shape on R1's upper arm, that wrapped around, appearing the same shape as a blood pressure cuff. DON E confirmed R1 was receiving an anticoagulant medication. DON E reported R1's primary provider was updated on the injury right away and had been to the facility to see R1, and staff to monitor R1 and do not take blood pressure on right arm due to the injury. DON E stated R1's primary provider did not question the facility's assessment; the bruise may have been caused by the blood pressure cuff or the mechanical sit-to-stand, as R1's primary provider trusted the facility's assessment. On 07/09/26 at 1:45 PM, Surveyor interviewed Certified Occupational Therapy Assistant (COTA) F. COTA F reported R1 was in therapy at the time the injury occurred. COTA F denied knowing how the injury occurred and denied any accident happened or being aware of any abuse occurring. On 07/09/26 at 2:10 PM, Surveyor interviewed Social Services Director (SSD) G and Nursing Home Administrator (NHA) A. SSD G and NHA A explained they did not feel this injury was a reportable incident on 06/15/26, as R1 denied anyone abused her and the initial cause of the injury was determined to be caused by a blood pressure cuff or a mechanical lift. NHA A and SSD G stated an internal initial investigation was completed within 24 hours and abuse had been ruled out. On 07/09/26, Surveyor informed SSG, NHA A, R1's injury meets the definition of injury of unknown origin, as R1 could not state how the injury occurred, R1's injury was not witnessed, and R1's injury is suspicious due to the extent of the injury. SSD G and NHA A continued to express confusion with the reporting process, and stated the facility reported the incident as soon as they became aware of the fracture and did not feel R1's initial bruise met the definition of injury of unknown origin.		