Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 0015955	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT COLBY (THE)	**1110 N DIVISION ST, COLBY, Wisconsin, 54421**

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N0000	Initial Comments On 09/08/2026 and 09/09/2026, Surveyor conducted 4 complaint investigations and a self-report review at The Waterford at Colby. Data was collected through 09/22/2026. Two of the 4 complaints were substantiated. One deficiency was identified. Census:40	N0000		
N0205	Not permit a condition of substantial risk. 83.14(2)(j) The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not reveal all details of a resident to resident altercation to ensure Resident 1 received prompt medical evaluation following the altercation. The provider used an electronic system that recorded 2 altercations in which Resident 1 suffered multiple blows to his/her head. The details from the video were not promptly provided to Resident 1's legal representative and health care provider to ensure Resident 1 received prompt medical evaluation, which placed Resident 1 at substantial risk of harm following a head injury. Findings include: On 06/16/2026, the Department received a report from the provider for a resident to resident altercation that involved law enforcement	N0205		

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N0205	Continued from page 1 intervention. The report indicated an altercation occurred between Resident 1 and Resident 2 at approximately 12:20 a.m. The report read, in part: "On 06/15/2026 staff received notification via phone call from Safely You fall detection system at 12:22:35 AM. Staff acknowledged call at 12:23:07 AM. Video from incident showed [Resident 2] entering [Resident 1] room at 12:19:53 AM. [Resident 1] got up from [his/her] chair and met [Resident 2] in the doorway and tried [sic] getting [Resident 2] out of [his/her] room. It appears pushing between both residents began in the doorway where altercation escilated [sic] to [Resident 2] pushing [Resident 1] backwards into nightstand and chair. [Resident 1] was on the ground when [Resident 2] then back hands [Resident 1] on side of head. [Resident 2] then sat on [Resident I's] bed. [Resident 1] got up and grabbed dust pan that was next to [his/her] bed. [Resident 1] & [Resident 2] pulled back and forth. Pushing and shoving each other. [Resident 2] pushed [Resident 1] again. [S/he] landed on night stand and [Resident 2] had dust pan which [s/he] then began swinging at [Resident 1] [Resident 1] got dust pan away from [Resident 2] and [Resident 2] reached for it [Resident 1] swung the handle at [Resident 2]. [Resident 2] then slapped [Resident 1] across the face and grabed [sic] [him/her] by the shirt color [sic] back into the wall and shoved [his/her] head toward the window then grabs [his/her] head and appears to be hitting [Resident 1] in the back of the head with one hand while clenching a handful of hair with the other hand and pulls resident on to [his/her] left side toward [him/her] [Resident 1] and [Resident 2] began pushing and shoving each other back and forth. [Resident 2] had color [sic] of [Resident I's] shirt and swang [sic] [Resident 1] on to ground in to woden [sic] chair fliped [sic] over on the floor and appears to hit [Resident 1] in the face. [Resident 1] swinging back at [Resident 2]. At 12:23:08 AM resident next door entered [Resident I's] room. At 12:23:23 AM staff entered residents room and got between [Resident 2] and [Resident 1] and called second staff member in for assistance at 12;23:41 AM. Second staff member assisted [Resident 1] up while first staff member stood between residents to avoid more confrntation [sic]. Second staff member exited area with [Resident 1] Once [Resident 1] was out of the room away from [Resident 2]. Staff evaluated [Resident 1] Contacted [Resident I's] POA (power of attorney) who came to facility and sat 1:1 with [Resident 1]. Staff called on call manager. Completed incident report. [Resident 1] obtained Injuries including Bruise to R (right) eye, scratch by right of nose, Bruise on right arm, small scratched along back, Bruise L (left) side back, Bruise L upper	N0205		

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N0205	Continued from page 2 arm & scratch, L butt cheek 2 Bruises. Was evaluated by hospice nurse and later evaluated at [hospital] emergency department. [Resident I's] MD's (medical doctors) and [managed care organization (MCO)] team notified. [Resident 2] MD notified, Along with POA. [Resident 2] was going to be sent to [hospital] ER (emergency room) for eval. (evaluation). Staff and EMTs (emergency medical technicians) unable to get resident to go with them law enforcement contacted and came to facility for assistance. Still unable to get [Resident 2] to go with ems (emergency medical services). Resident's POA/[spouse] was contacted and came to facility. Staff was able to get resident to go in [spouse's] car and be taken to [hospital] E.R. Shortly after Aps (adult protective services) came to facility and was given the information needed regarding altercation. For the safety of resident and resident involved [Resident 2's] POA was notified that resident needs 24/7 1:1 monitoring to return to our facility and specialized facility was suggested for ecalation [sic] of behaviors." The incident report indicated Caregiver C and Caregiver D were the staff that were working when this incident occurred. On 06/17/2026, the Department received 2 complaints regarding concerns with resident's rights along with program services when altercations occurred at the facility. The provider is licensed to care for up to 48 residents in the following client groups: terminally ill, advanced age, physically disabled, and irreversible dementia/Alzheimer's disease. The facility has an assisted living side and a secure memory care unit, named Magnolia Trails, with delayed egress doors. "Traumatic brain injury (TBI) is a significant health concern among the elderly, and with the growing population of older adults in North America and globally, the problem is becoming more significant. According to the Centers for Disease Control and Prevention, in the United States the number of TBIs that occur each year among older adults ages 65 years and older is estimated at 237,844 [1]. TBI is responsible for more than 80,000 emergency department (ED) visits each year in this age group alone; three quarters of these visits result in hospitalization. Falls are the leading known external cause of TBI in this age group, representing almost two thirds of the total. Other mechanisms include motor vehicle traffic-related TBI (8%), struck by or	N0205		

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N0205	Continued from page 3 against objects (6%), assaults (1%), and, interestingly, 25% are unknown [1] ... Overall, older trauma patients experience more complications and higher long-term morbidity and mortality for any specific injury than younger individuals with trauma [6, 7]. It is widely accepted that older age is associated with poorer outcome following TBI including higher mortality and increased functional disability [8-10]. The interaction of complex comorbid medical conditions, medications, premorbid cognitive difficulties, and the unique physiology of the aging brain makes it more challenging for the clinician to assess and monitor brain injury and responses to therapeutic interventions ... With age, the brain atrophies and creates more space within the cranial vault for blood to accumulate before symptoms appear. Therefore, elderly people can have significant hemorrhage into their brain and not show signs of deterioration. Currently, a CT scan of the head is the most common diagnostic tool to evaluate acute TBI in the elderly [16]. It can reveal traumatic intracranial injuries such as contusions, brain lacerations, and hemorrhage leading to the formation of hematoma in the extradural, subarachnoid, subdural, or intracerebral compartments within the head. The American College of Emergency Physicians recommends a head CT scan for any patient age 65 years or older who presents with mild head injury." (Papa, L., Mendes, M. E., & Braga, C. F. (2012). Mild Traumatic Brain Injury among the Geriatric Population. Current translational geriatrics and experimental gerontology reports, 1(3), 135-142. https://doi.org/10.1007/s13670-012-0019-0). On 09/08/2026 at approximately 4:30 a.m., Surveyor interviewed Caregiver **F,** who was working on the assisted living side of the facility. Caregiver F told Surveyor there were 2 staff that worked from 10:00 p.m. until 6:00 a.m. Caregiver F said Caregiver G was working on the memory care unit. Surveyor asked if staff had to leave their assigned units to assist each other. Caregiver **F** explained that Resident 3 typically got up for the day around 5:00 a.m. and Resident 4 also got up for the day between 5:00 and 6:00 a.m. Caregiver F said Resident 3 and Resident 4 both required 2 staff to assist with a mechanical lift to get out of bed. Resident 3 and Resident 4 were on the assisted living side of the facility. Staff from the memory care unit would have to leave that unit to assist staff on the assisted living side to transfer Resident 3 and Resident 4 out of bed. On 09/08/2026 at approximately 4:50 a.m., Surveyor	N0205		

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N0205	Continued from page 4 interviewed Caregiver G who was working on the memory care unit. Caregiver G told Surveyor there was 1 staff member on each side of the facility during the overnight shift. Caregiver G explained they have a work phone that they chart with and that also alerts them for the Safely You cameras that will trigger if a resident falls or rolls out of bed. Caregiver G told Surveyor Resident 1 and Resident 2 no longer resided at the facility. Caregiver G said Caregiver C no longer worked at the facility. On 09/08/2026 at approximately 5:10 a.m., Associate Administrator (AA) E arrived at the facility. Surveyor interviewed AA E and explained the purpose of the survey. AA E provided Surveyor with requested documentation including their investigation into the incident with Resident 1 and Resident 2 and a timeline of events. On 09/08/2026, Surveyor reviewed the provider's investigation summary. The investigation summary was dated 06/22/2026, and signed by Executive Director (AD) A. The summary read: "[Resident 1] and [Resident 2] altercation on 6/15/26 investigation: I had numerous communications with the caregiver on the Magnolia Trails unit when this altercation happened. [Caregiver CJ was in [Resident 1's room] within 30 seconds of receiving the Safely You alert. [s/he] did call for help from the AL (assisted living) caregiver and did separate [Resident 1] and [Resident 2] swiftly. - Per [Caregiver CJ [s/he] felt overwhelmed and [his/her] number one priority was resident safety. - Per [Caregiver CJ [s/he] called and texted POA [Person HJ who came in to sit with [Resident 1] and keep [him/her] safe. - Per [Caregiver CJ [Person HJ took pictures of the injuries and was not interested in having [Resident 1] sent out for an eval (evaluation). - Per [Caregiver CJ [his/her] focus was keeping [Resident 2] away from [Resident 1] and	N0205		

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N0205	Continued from page 5 distracted/entertained. - Per [Caregiver C] [s/he] called the on-call manager and when [s/he] didn't answer [s/he] called [him/her] again and [s/he] did not answer. [S/he] then discontinued calling to assist resident's [sic] and keep a careful eye on [Resident 2]. - Per [Caregiver C] [s/he] did not call Hospice or 911 as [s/he] was overwhelmed and [his/her] focus was safety and no further altercations. *Management arrived at approximately 7am. [Clinical Coordinator (CC) I] saw Hospice was in shortly after and let them know to evaluate [Resident 1] at that time. *[Memory Care Director (MCD) J] spoke with [Person H] upon arrival ([Person H] was with [Resident 1]) and came up with a plan for [Resident 1's] day together. [Person H] wanted [Resident 1] to have as normal of a day as possible per [Person H] and [MCD J] - this included joining all activities *Carestaff [sic] did a skin assessment on [Resident 1] and gave it to the Wellness director. *Hospice did their assessment and did not give any directives that further care was needed for injuries. *Wellness notified MD via fax and [MCO] of incident. MD suggested a higher level of care for [Resident 1] due to multiple instances of altercations that involved this resident. *Care conference was held on 6/17/26 with [MCO], POA, guardian, Ombudsman, APS, Wellness Director, clinical coordinator, Hospice, and myself. 30 day involuntary termination notice was given to POA/guardian/ombudsman/[MCO] that this resident would benefit from a higher level of care. *An all staff meeting was held on 6/17/26 to further educate carestaff [sic] regarding resident to resident altercations, policies and procedures for communications with POA's, guardian, management, etc. Careplans and following all interventions for	N0205		

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N0205	Continued from page 6 resident's [sic] when behaviors happen. Hospice notifications and when to call 911 during emergent circumstances or altercations." On 09/08/2026, Surveyor reviewed the provider's timeline of events. The timeline read: "5/15/26 - 30 day involuntary termination notice sent to [Resident I's] representatives regarding increased behaviors for [his/her] safety/other resident's safety. 5/29/26 - 1st altercation between [Resident 2] and [Resident 1] • [Resident 2] had just admitted late that afternoon • [Resident 2] had no prior history of physical altercations based on the pre-admission assessment • FACTS: [Resident 2] walked in [Resident I's] room, [Resident 1] grabbed [Resident 2's] arms and tried to push [him/her] out of [his/her] room. [Resident 2] pushed [Resident 1] back and slapped [him/her]. [Resident 1] fell back over a box. Safely You was alerted. [s/he] slapped and pushed [Resident 2]. [S/he] fell over bed. Staff intervened. Interventions: Reached out to MD - [Resident 2] started new medication for behaviors Care staff to lock [Resident I's] door as able ([s/he] is in and out so not always possible) [Resident 2] - [Name] home care started coming in 9 hours per week in evenings to help manage behaviors. Carestaff [sic] and wellness monitoring [Resident 2] for appropriate interventions to careplan 6/8/26 - 2nd altercation between [Resident 2] and	N0205		

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N0205	Continued from page 7 [Resident 1] • [Resident 1] took [Resident 2's] walker, hit resident, grabbed [his/her] belt loop. • [Resident 2] did not reciprocate Interventions: • Education with staff regarding noticing behaviors and intervening immediately 6/15/26 - 3rd altercation [Resident 2] and [Resident 1] • [Resident 2] entered [Resident l's] room. [Resident 1] proceeded to try to push [Resident 2] out and [s/he] became very violent. • [Resident 2] sent out and referred to higher level of care due to the extent of the violence inflicted upon [Resident 1]. 6/17/26 • Care conference with [MCO], guardian of [Resident 1], POA of [Resident 1], APS, Ombudsman, W.D. (Wellness Director), Mag (Magnolia) Trails Director, Hospice, myself • 2nd 30 day involuntary termination notice given to all parties regarding [Resident 1] for [his/her] safety and other residents." On 09/08/2026 at approximately 8:30 a.m., Surveyor interviewed AA E. Surveyor asked who the manager was that did not answer their phone when Caregiver C called on 06/15/2026 after the altercation between Resident 1 and Resident 2. AA E told Surveyor, Caregiver C called Wellness Director (ED) B. AA E told Surveyor that staff were trained that they should continue calling management until someone answers their phone. AA E said if WD B did not answer, Caregiver C should have called the next manager in line.	N0205		

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N0205	Continued from page 8 On 09/09/2026 at approximately 12:40 p.m., Surveyor interviewed WD B. WD B said s/he had one missed call from Caregiver C after the altercation between Resident 1 and Resident 2. WD B said s/he did not wake to his/her phone when Caregiver C called. WD B said Caregiver C was a staff that would normally call a thousand times, but this time s/he only called once. WD B said Caregiver C should have reached out to the other managers. WD B said when s/he started his/her shift on 06/15/2026, s/he reviewed the incident report with CC I. WD B said Person H and hospice staff were already at the facility when WD B and c c I arrived for the day. WD B said CC I talked to Person H and hospice staff. Surveyor asked what staff were supposed to do after there is a resident to resident altercation, when a resident received strikes to their head. WD B told Surveyor, staff should tend to the resident, call on-call, call hospice, if they were on hospice and call the resident's power of attorney. From 09/09/2026 until 09/22/2026, Surveyor reviewed Resident I's records from the provider, managed care organization (MCO), hospice, hospital, law enforcement, and adult protective services (APS). PROVIDER RECORD Resident 1 was at admitted to the facility on 04/27/2024. S/he had multiple diagnoses including cognitive decline, dementia, depressive disorder, and insomnia. Resident 1 had an activated healthcare power of attorney, Person H, and a guardian of finances, Person K. Resident 1 had a MCO nurse and case worker. Resident I's individual service plan (ISP), dated 06/24/2026, read, in part: "Identified as fall risk... Safely, you video fall detection program, Consent signed by POA.. COGNITION/ORIENTATION Needs/Details Ongoing assistance with care due to advanced dementia with speech, functional, and behavioral impairments... MC (memory care) RESIDENT: Has a history of wandering or elopement... DISPOSITION AND BEHAVIORS Needs/Details Interventions needed due to disruptive, aggressive, or socially inappropriate behavior... The resident sometimes has a hard time communicating. Or words don't come out as [s/he] would like. [sic] and the resident may become	N0205		

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N0205	Continued from page 9 agitated when [s/he] is not able to communicate and get words out as [s/he] would like. When the resident wants your attention and isn't able to express it verbally, [s/he] grabs your arm or smacks you to get your attention." A note dated 05/29/2026, read: "Safely you went off at 1:20am. Writer and other staff watched the safley [sic] you video. In the Safely you video that writer and staff watched it showed [Resident 1] sleepin [sic] gon [sic] [his/her] bed, when [Resident 2] goes into [Resident l's] room. [Resident 1] got up from [his/her] bed and tried to get [Resident 2] out of room. [Resident 2] pushed [Resident 1] onto the floor, tried to kick [Resident 1] and started slapping [Resident l's] face. [Resident 1] was kneeling on the floor and [Resident 2] contiune [sic] hitting [Resident 1] across [sic] [Resident l's] face and head. Writer and staff went into [Resident l's] and saw [Resident 2] standing over [Resident 1]. Staff tried to get [Resident 2] out of [Resident l's] room and staff tried to get [Resident 1] off the floor. [Resident 1] punched staff acrross [sic] the face. Writer got [Resident 1] into the med (medication) room and took vitals. Writer walked [Resident 1] back into room. When [Resident 2] saw [Resident 1] and writer walking [Resident 2] got up and tried going into [Resident l's] room. Writer [sic] started screaming and swinging at writer and staff. [Resident 2] kept telling staff to ' get away from me ' Writer and staff were being followed by [Resident 2]. Throughout the common area, after 10-15mins (minutes) later [Resident 2] finally sat down on one of the common area chairs." On 05/31/2026, Caregiver C documented a comment to this note, which read: "When family of [Resident 1] was notified, [s/he] was told that [s/he] can't be disclosed any details accept [sic] that there was a confrontation between [s/he] and another resident. all [s/he] wants to know is was [s/he] hurt and did [s/he] start it." Another note, dated 05/29/2026, read: "Staff were on AL (assisted living) side sending another resident out by ambulance when safely you went off. Staff ran back to [Resident l's] room, where staff seen [Resident 1] on the floor and [Resident 2] standing over top of [him/her]. Staff tried to get [Resident 2] out of [Resident l's] room. [Resident 2] started screaming at staff. Staff tried to get [Resident 1] off the floor when [Resident 1] punched staff in the face and grabbed staff, staff finally got [him/her] up when [Resident 2] swung at staff almost making contact. Staff called [initials] told [him/her] what is going on, staff put [him/her] on speaker so [s/he] could try to	N0205		

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N0205	Continued from page 10 talk to [Resident 2]. [Resident 2] wasn't listening to [him/her] at all. Staff got [Resident 1] into the medroom [sic]. [Resident 2] started going after staff swing [sic] at staff and told staff if they closer [sic] [s/he] will punch us right in the mouth. Wrier [sic] called [Resident 2's POA] [s/he] told writer [s/he] has never acted like this. Writer told POA it was ok but writer has to call POA of the resident involved. [Resident 2's POA] said [s/he] doesn't sleep in a bed and [s/he] doesn't watch tv. Writer asked [Resident 2's POA] if [s/he] could put [Resident 2's POA] on speaker to see if maybe [Resident 2] hearing [his/her] voice would help calm [Resident 2] down. [Resident 2's POA] told writer it would not help and told writer Goodluck [sic]. Writer called [Resident I's POA] it would not help and told writer Goodluck [sic]. Writer called [Resident I's] POA [Person H]. Writer told [Person H] there was an altercation between [Resident 1] and another resident. POA said ok and hung the phone up. [Person H] called back and demand details. Wrtier [sic] told [him/her] [s/he] could not give [him/her] any and that [Resident 1] was ok. [Person H] hung up the phone." The incident report indicated there were no apparent injuries. The incident report indicated MCD J was notified at 1:37 a.m., Resident 2's POA was notified at 1:35 and Resident I's POA was notified at 2:01. The time notifications to the POAs did not include a.m. or p.m. "No" was marked for transfer for treatment. The report indicated the MCO for Resident 1 was called at 2:18 a.m. The report indicated Resident I's and Resident 2's physicians were notified via fax. Staff documented the following intervention: "Separate residents, contact [Resident 2] PCP (primary care physician) for medication to help with evening/ bedtime agitation. [Resident 1] lock door at night to avoid other residents wandering in room." On 06/01/2026, MCD J documented the following note: "I was informed by staff POA wanted me to call [him/her]. I called [him/her] back. [S/he] had questions about the incident from last week. I told [him/her] I would have to talk to [name] and get back to [him/her] since the incident involved another resident. While I was waiting for [name] to be available [Person H] arrived at the facility. [Person H] requested we talk in the hall outside of mag trails. [Name] and I listened to [Person H's] concerns. [S/he] has concerns about medications because of previous experiences. [S/he] also talked about how [s/he] has seen staff at other facilities be the cause	N0205		

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N0205	Continued from page 11 of behaviors in residents and was wondering if some of the incidents with resident had been exaggerated. [s/he] was also concerned about the 'secrecy' around the last incident. We explained that in this last incident resident was not the aggressor and we were protecting confidentiality, not trying to be secretive. We told [him/her] the incidents that were documented were justified incidents. We assured [him/her] that we understand our actions can affect the residents and we are doing everything we can to prevent any further incidents. [Person H] and I went into [name's] office at this point and [name] explained the training that staff are required to take I further explained the incident in question without breaching confidentiality. [Name] also explained to [Person H] that with resident not being the aggressor in this incident it will not be held against [him/her]." On 06/15/2026, staff documented: "2 resident dispute that got physical fast. Safley [sic] you went off when writer went in writer had to stand between [Resident 2] and [Resident 1]. [Resident 2] was beating [Resident 1] up when writer went back to watch video writer saw a lot that should never happen being hitting, kicking and punching." The note indicated the date and time was 06/15/2026 at 1:50 a.m. The incident location was resident's room and injuries included: scratches and bruising. There were 5 comments added to the above note: On 06/15/2026 at 11:45 a.m., CC I documented the following comment: "When writer watched Safely you video, Writer seen [Resident 2] come into [Resident I's] room, [Resident 1] was sitting in [his/her] chair watching tv and got up and tried to get [Resident 2] out of [his/her] room. [Resident 2] then started hitting and grabbed [Resident 1] and pushed [him/her] into the air conditioner. [Resident 1] then got up and grabbed the broom and tried hitting [Resident 1] [sic], [Resident 2] then grabbed the broom stick from [Resident 1]. [Resident 1] then grabbed it back from [Resident 2] and was standing, they were fighting over it and that's when [Resident 2] grabbed [Resident 1] again and was pushing [his/her] head on the window and was pulling [his/her] hair. That's when the chair fell and [Resident 2] still had a hold on [Resident 1]. [Resident 1] tried getting away from [Resident 2] and then fell onto the chair. [Resident 2 still had [Resident 1] by [his/her] hair and shirt. That is when [resident] walked into the room to see what was going on, then [Caregiver C] was right behind	N0205		

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N0205	Continued from page 12 coming into the room also. [Caregiver C] then got in-between [Resident 1] and [Resident 2] and called [Caregiver D] to come assist. When [Caregiver D] came into the room [Resident 1] got up and [Caregiver D] took [him/her] out of the room. [Resident 2] was left in [Resident I's] room alone, then came out of room on [his/her] own." On 06/15/2026 at 4:02 p.m., WD B documented the following comment, which was a statement from Caregiver C. The note read: "I had just finished destroying medications, filling out paperwork and documents, I started to clean up the dinning [sic] area by picking up trash and straight lining up furniture that residents has [sic] moved and displaced. I noticed what the time was, went to the medcart [sic] punch out the meds (medications) that i [sic] needed to. Went into a residents [sic] room gave medicine and repositioned [him/her]. [S/he] needed to be changed. I changed [him/her] got [his/her] clothes back on and left. Realized I hadn't touched the laundry. I reached for my keys when I heard [resident] yelling at [Resident 2] to stop and i ran into the room [Resident 1] on the floor and [Resident 2] just let go of [him/her] and started hitting and swinging. I threw myself between them called [Caregiver D] ... [Caregiver D] got [Resident 1] away and I waited for [Resident 2] to be in a decent state of my [sic] to escort [him/her] out and to [his/her] room. I then evaluated [Resident 1] and got vitals on [him/her]. [Resident 2] was good and was fine but I really put a lot [sic] of time and effort into [Resident 1] [s/he] was shook up and had injuries and I called poa and [s/he] came. I couldn't disclose to [sic] much for obvious reasons but [s/he] came and got [him/her] to settle. I gave [him/her] a piece of cake and sat with them. Then I reached out to [WD B] and started filling out my reports... I then was called over to help with [resident] (left mt [Magnolia Trails] no one there) By this time I gathered myself the papers and made sure things looks [sic] presentable then had stand up. - [Caregiver C]." On 06/15/2026 at 5:35 p.m., WD B documented the following comment: "Received a call from the resident's [family] that the resident was at the ER (emergency room) at [name] in [city] for evaluation and [hospital] was requesting a fax of POA documents. The writer faxed ER" On 06/15/2026 at 8:38 p.m., WD B documented the following comment: "writer was notified resident	N0205		

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N0205	Continued from page 13 was on [his/her] way back to facility and that CT (computed tomography) came back fine and resident could receive acetaminophen as needed for pain" On 06/22/2026 at 5:51 p.m., WD B documented the following comment: "[WD B] contacted POA to follow up with the incident if there where [sic] anymore issues or concerns. POA stated [s/he] just wanted to see the video. Writer informed POA [s/he] was not certain how that all works, but would reach out to higher-ups and find out and contact POA when [WD B] had more answers." On 06/22/2026, WD B documented: "Care conference scheduled 6/17/2026, with Hospice team, POAs, [MCO], Ombudsman, APS, and Waterford Management, to assist with interventions and help with resident behaviors. - no resolution. Waterford staff were asked to leave during the meeting, and no assistance for the behaviors or interventions was provided from outside sources." On 06/24/2026, WD B documented: 'WD just notified of Resident moving to [name], Received Request for Medication List and Care plan to be faxed over." On 06/24/2026, WD B documented the following comment: "Facility Just Informed resident will be moving out today at 3:30 PM" MCO RECORD Surveyor requested and reviewed case notes on Resident 1 from 03/01/2026 until 07/01/2026. On 05/29/2026, MCO Case Manager (CM) P documented the following note: "Received a fax from [CC I], Waterford lead wellness supervisor, with an incident report attached. The report states that on 5-29 at 1:20am [Resident 1] had an unwitnessed altercation with another resident. I emailed [CC I] asking for more details. I asked [him/her] what occurred and how they knew what happened when the report states that it was unwitnessed. [CC I] responded that it was detected via their camera system. Staff responded after the other resident left [Resident I's] room. Per [CC I], another resident came into [Resident I's] room at the time of the	N0205		

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N0205	Continued from page 14 incident. [Resident 1] got out of bed and tried getting the other resident to leave and this is when the altercation started. I responded to [CC I] asking what actually happened during the altercation." On 06/01/2026, CM P documented a note, which read, in part: "While on the phone [Person H] did update that [s/he] spoke to Waterford staff today regarding an incident that happened at 2am recently. Per [Person H], someone came into [Resident I's] room and [s/he] was defensive with them. [Person H] was at first unable to get information and was told by staff that only management is able to provide the information. Per [Resident 1] [sic], [s/he] does not know who came into [Resident I's] room or what was done other than an altercation resulted." On 06/02/2026, CM P documented a note, which read, in part: "TC (telephone call) with [Hospice Registered Nurse (HRN) Q], to discuss recent contact with [Resident 1]. [HRN Q] states that [s/he] does not feel that the notice is valid and that [s/he] does feel that [Resident 1] is being targeted. [HRN Q] states that [s/he] did learn more information regarding the 2am incident in [Resident I's] room including that it was a [wo/man] that came into [his/her] room. [HRN Q] has reached out to the facility to schedule a care conference but has not received a response..." On 06/15/2026, CM P documented a note, which read, in part: "TC from [Hospice Social Worker (HSW) M], who asked if I had been made aware of the incident that occurred last night with [Resident 1]. I let her know that I had not. Per [HSW M], the incident occurred in [Resident I's] room. Another resident entered [Resident I's] room and beat [him/her] up. [Resident 1] did nothing wrong during the incident. [S/he] suffered a black and blue right eye, cuts on [his/her] face, two large gashes on [his/her] arm and bruises on [his/her] bottom. Per [HSW M], staff working had to call for back-up to help remove the other resident from [Resident 1] ... i asked [HSW M] if the incident was reported to DQA (Division of Quality Assurance) and [s/he] states that [s/he] is unsure. They did ask Waterford for a copy of the incident report and were told that they could not provide this to outside sources ... Email sent [WD B], and [CC I], lead wellness staff, as well as [HSW M]. In my email I let Waterford staff know that I heard about the incident last night. I asked for the incident report for our reporting purposes and if they would be self reporting the incident to DQA. [WD B] responded that they self report to the state.	N0205		

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N0205	Continued from page 15 [s/he] states that they cannot send the incident report but will send a message with info pertaining to the event. I responded that we would also need to know if the other person involved was an [MCO] member. We would also need to know if hospice was contacted right away or the next morning and if the PD (police department) was involved. Email from [HSW M] asking if I received a response. I let [him/her] know that I had not. [HSW M] responded, voicing [his/her] frustrations. [s/he] states that [s/he] does not feel like the incident is being taken seriously. [s/he] states that they informed Marathon County this morning but [s/he] was unsure if they planned to investigate... Sent a second email letting [him/her] know that we will need to know how staff are ensuring [Resident I's] health and safety moving forward. I asked if the other resident is still in the building and if staff will be added to ensure things have quieted down. Email from [WD B] who states that the other resident is not at the facility. [S/he] states that the PD was there along with APS. Per [WD B], [s/he] is working on getting all the details of what happened so [s/he] can give correct information. [S/he] states that [s/he] is working on notifying everyone. Received incident report via fax from Waterford. Per the report, the incident occurred on 6/15 at 1:50am. The report states that an altercation occurred between [Resident 1] and another resident. The other resident entered [Resident I's] room and [Resident 1] attempted to remove [him/her]. The altercation escalated rapidly and was physical. [Resident 1] suffered a bruised left eye, scratch by the right side of [his/her] nose, bruise on [his/her] right arm, small scratches along [his/her] back, bruise on the left side of [his/her] back, bruise on [his/her] left upper arm and a scratch, as well as two bruises on [his/her] left butt cheek. Per the report [Resident 1] was evaluated by hospice. Email sent to [WD B] asking who alerted APS and the PD for our report. [ED A] replied that they alerted both agencies when the other resident refused to leave with the EMTs following the incident. The other resident was exited shortly after this. [HSW M] replied, only to me, that they contacted Marathon County APS this morning..." On 06/16/2026, MCO Care Coordinator (CC) L documented a note which read, in part: "E-mail from [Adult Protective Services Worker (APSW) N]. [APSW N] wrote that [his/her] agency has concerns with the response of the Waterford related to the physical abuse [Resident 1] sustained from another resident on their memory care unit on 6/15/26. [APSW N] viewed a video of the altercation and reports that the video recording from 5/29/26	N0205		

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N0205	Continued from page 16 closely mirrors the event from 6/15/26. [APSW N] contacted [Person H] who stated the facility never offered to [him/her] details about what they observed to occur in the video. [APSW N] reports that the video showed [Resident 1] getting hit in the face, [his/her] hair pulled, falling back and hitting [his/her] head on items in [his/her] room, getting struck repeatedly with a cane. APS strongly encouraged [Person H] to get [Resident 1] evaluated at the local ED and for the ED to take photos of [his/her] bruising for records. APS's recommendation is for alternative placement be considered due to how the facility responded to this event including lack of immediate medical attention for the client, lack of reporting to APS, lack of report to DQA, and refusal to provide [Person H] or other care providers incident reports related to the event." On 06/17/2026, MCO CCL documented a note which read, in part: "IDT (interdisciplinary team) staff met at Waterford to complete [Resident 1's] 6 month My Plan review and to have meeting with APS, family members of [Resident 1], and Waterford staff and Waterford leadership, hospice providers, and ombudsman. [APSW N], [ED A], [HRN Q], [CC I], [WD B], [Person K], [Person H], [HSW M] and [HSW R], and [Ombudsman S] were all in attendance... Meeting with [APSW N] leading began. [APSW N] stated that [s/he] saw the video of the assault on [Resident 1] by another resident and stated that it was the worst thing that [s/he] had ever watched of a resident-to-resident altercation. [Resident 1] was shoved down on the floor hitting [his/her] head, had [his/her] hair pulled, and was repeatedly struck with a cane. Discussion was had about any previous incidents involving this offending resident and **[APSW N]** stated that [s/he] had not received any other reports and requested that reports of all previous incidents involving [Resident 1] be sent to [him/her] ... June 15th the IR (incident report) was sent to DQA (Division of quality Assurance) on the 16th. Family reports that they requested the IR for the incident and was informed that they could not have that report. Family was notified on 1:50 am on the 15th but hospice was not notified until the next morning. Video time shows the incident started at 12:22 AM. Hospice stated that if they had been notified, they would have assessed immediately... Family was asked if they had received a call following the	N0205		

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N0205	Continued from page 17 incident and they stated no, but they were notified by text. [Family] arrived as soon as [s/he] was able to get there. Discussion was had regarding the 30 [sic] notice that originally had been rescinded. [ED A] stated that Waterford legal department is issuing another/new 30-day notice as of today. It was decided by [APSW NJ that the balance of the meeting would be completed without Waterford leadership or staff present so that the family could speak freely regarding their thoughts regarding the incident and plans going forward. Waterford staff left the meeting. [APSW NJ stated that [s/he] is advocating that POA look for alternate placement for [Resident 1]. Hospice SW stated that [s/he] does not believe that [Resident 1] is receiving unbiased care at the Waterford. [APSW NJ stated that [s/he] is unsure if Waterford can provide safe care for [Resident 1] going forward. Timeline of incident discussed. 12:19 other resident entered [Resident I's] room. 12:22 incident started. 12:27 staff entered the room. [Family] came in and took photos of [Resident 1] at 1:45 am. Family notified hospice at 7:08 the next morning. Hospice arrived at the facility at 9:30 am. [Resident 1] reported no pain. Discussion was had about the word gash on the report that [MCO] received. Hospice stated a heavy scratch would be more accurate. APS had recommended that [Resident 1] be taken and evaluated following the incident and a CT (computed tomography) scan of [Resident I's] head had been done at [Hospital] ... IDT ended visit by going to see and visit with [Resident 1]. [Resident 1] was seated in the community area with a group listening to a musical group preform [sic]. [Resident 1] stated that [s/he] was not having any pain. It was noted that [Resident 1] had a bruise to [his/her] forehead, a right bruised eye, scratch to right side of nose, close to nostril. Heavy scratched [sic] to [his/her] forearms."	N0205		

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N0205	Continued from page 18 HOSPICE RECORD On 05/29/2026, a hospice triage RN documented: "TRIAGE NOTE 219 AM CST. (2:19 a.m. central standard time) CALL FROM [Caregiver T] AT FACILITY TO REPORT AN ALTERCATION WITH ANOTHER RESIDENT. PT (patient) **WAS IN** ROOM WHEN ANOTHER PT WALKED IN [HIS/HER] ROOM CAUSING AN ALTERCATION BETWEEN RESIDENTS. THIS WAS CAUGHT ON CAMERA. PT IS FINE. DENIES ANY PAIN ..." On 06/15/2026, Hospice Registered Nurse (HRN) Q documented a narrative which read, in part: "TEXT MESSAGE RECEIVED FROM [Person HJ AT 0708 (7:08 a.m.) ALONG WITH 3 PHOTOS SHOWING BRUISING. IN THE TEXT MESSAGE [Person HJ STATED THAT AT 0130 (1:30 a.m.) ANOTHER RESIDENT ENTERED PATIENTS ROOM CAUSING AN ALTERCATION WHICH CAUSED THE BRUISING AND [His/HER] WOODEN STATIONARY CHAIR IN [HIS/HER] ROOM ENDED UP BROKE.. INFORMED [Person HJ THAT WRITER WILL BE COMING TO THE FACILITY FOR A VISIT. WRITER ARRIVED AT THE FACILITY AND UPON ENTERING SPOKE TO [CC I], TEAM LEADER. [CC I] STATED THERE WAS AN INCIDENT OVER NIGHT BUT PATIENT WAS NOT AT FAULT, [S/HE] ASKED IF ANYONE FROM THE FACILITY HAD CONTACTED HOSPICE AND INFORMED [CC I] THAT IT DOES NOT APPEAR HOSPICE WAS CONTACTED OR INFORMED OF THIS UNTIL [Person HJ TEXTED WRITER THIS MORNING. ASKED [CC I] WHAT HAPPENED AND [CC I] STATED THAT THEY ARE UNABLE TO SHARE ANY OF THIS INFORMATION, ALSO ASKED TO FAX THE INCIDENT REPORT TO THE OFFICE BUT [CC I] STATED THAT THEY ARE UNABLE TO SHARE THIS DOCUMET[sic]. [CC I] LET WRITER INTO THE LOCKED UNIT AND WE BOTH WENT TO SEE PATIENT. PATIENT WAS UP IN [HIS/HER] ROOM WITH [Person HJ PRESENT AND THEY WERE DANCING AND LISTENING TO POLKA MUSIC. PATIENT WAS HAPPY, PLEASANT. [Person HJ GAVE [HIM/HER] A SHOWER AND NOTED QUITE A BIT OF BRUISING ALL OVER [HIS/HER] BODY. ASKED PATIENT TO SIT DOWN WITH WRITER IN WHICH [S/HE] DID ON [HIS/HER] BED BUT HAD SOME GRIMACING AND TOUCHING [HIS/HER] LEFT BUTTOCK AS [S/HE] SAT. UPON ASSESSMENT DID NOTE A LARGE BRUISE TO [HIS/HER] LEFT BUTTOCK WITH SCATTERED SMALLER BRUISING TO LEFT HIP. VITALS OBTAINED= WNL (within normal limits). HRR (heart regular rate and rhythm). LUNG SOUNDS ARE	N0205		

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N0205	Continued from page 19 CLEAR WITH POOR AIR FLOW THROUGH OUT. ABDOMEN IS SOFT AND NONDISTENDED. ACTIVE BOWEL SOUNDS X 4. NO EDEMA TO BLE (bilateral lower extremities). WITH STANDING PATIENTS GAIT APPEARS STEADY. CONVERSATION IS NONSENSICAL PER [HIS/HER] NORMAL. PATIENT DOESN'T RECALL ANY EVENTS OVER NIGHT. DOES NOT APPEAR TO HAVE ANY TROUBLE WITH [HIS/HER] VISION. BRUISING: RIGHT OUTER EYE- BRUISING WITH SWELLING. LEFT UPPER ARM - RAISED LINEAR SCRATCH TO [HIS/HER] LEFT UPPER ARM (14 CM (centimeters) X 1 CM) WITH SURROUDING [sic] BRUISING AND WARMTH/TENDERNESS TO THE TOUCH. RIGHT FOREARM - LINEAR SCRATCH WITH SURROUNDING BRUISING (8 CM X 1 CM) LEFT BUTTOCK - **DARK** PURPLE/BLUE ROUND BRUISING **(8 CM X** 6 **CM),** TENDERNESS TO TOUCH LEFT BUTTOCK/LEFT HIP - LIGHT COLORED GRAY/BLUE BRUISING SCATTERED, UNMEASURABLE LEFT FLANK/MID BACK- LIGHT COLORED GRAY/BLUE BRUISING SCATTERED, UNMEASURABLE, TENDERNESS TO TOUCH. TEXT MESSAGE RECEIVED FROM [Person H] AT 1659 (4:59 p.m.) STATING [S/HE] GOT A CALL FROM APS AND [S/HE] IS GOING TO BE TAKING [Resident 1] TO THE [Hospital] ED (emergency department), [city]. CALL PLACED TO [Person H] TO DISCUSS AND ADVISED TO INFORM THEM [S/HE] IS ON HOSPICE AND TO CALL WRITER WITH ANY QUESTIONS/CONCERNS AND ONCE PATIENT IS BACK AT FACILITY FOR WRITER TO COMPLETE A TUCK-IN VISIT. CHECKED IN AND OUT WITH [CC I] AT FACILITY..." On 06/15/2026, HRN Q documented a narrative note that read, in part: "RN VISIT - PRN (as needed),	N0205		

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N0205	Continued from page 20 FOLLOW-UP ED VISIT FROM PHYSICAL ASSAULT... [Person H] TOOK PATIENT INTO THE [Hospital] ED IN [city] FOR EVALUATION AFTER PHYSICAL ASSAULT. RETURNED AT APPROXIMATELY 2045 (8:45 p.m.) WITH [Person H]. WRITER ASSISTED RESIDENT OUT OF THE CARE [sic] AND WALKED WITH [HIM/HER] INTO FACILITY. IN THE ED PATIENT HAD A CT OF [HIS/HER] HEAD WITHOUT INTRAVENOUS CONTRAST. CT SCAN WAS UNREMARKABLE. [S/HE] DID RECEIVE A 1 TIME DOSE OF HYDROXYZINE PRIOR TO CT SCAN. DISCHARGE ED DIAGNOSIS: TRAUMATIC ECHYMOSIS OF EYEBROWN [sic], LEFT UPPER ARM, RIGHT FOREARM, BUTTOCK, INJURY D/T (due to) PHYSICAL ASSAULT, DEMENTIA, ABRASION OF FACE, TRAUMATIC ECCHYMOSIS OF LEFT ELBOW. [Person H] ASSISTED PATIENT INTO PAJAMAS AND WAS GOING TO STAY WITH [HIM/HER] UNTIL [S/HE] GOES TO BED. PATIENT WAS IN GOOD SPIRITS UPON [HIS/HER] RETURN, HAD A SNACK AND A GLASS OF CHOCOLATE MILK. [Staff], FACILITY CAREGIVER WAS GOING TO GIVE PATIENT [HIS/HER] HS (bedtime) MEDICATIONS. BRUISING: RIGHT OUTER EYE- BRUISING WITH SWELLING. LEFT UPPER ARM - RAISED LINEAR SCRATCH TO [HIS/HER] LEFT UPPER ARM (14 CM X 1 CM) WITH SURROUDING BRUISING AND WARMTH/TENDERNESS TO THE TOUCH. RIGHT FOREARM - LINEAR SCRATCH WITH SURROUNDING BRUISING (8 CM X 1 CM) LEFT BUTTOCK - DARK PURPLE/BLUE ROUND BRUISING (8 CM X 6 CM), TENDERNESS TO TOUCH LEFT BUTTOCK/LEFT HIP - LIGHT COLORED GRAY/BLUE BRUISING SCATTERED, UNMEASURABLE LEFT FLANK/MID BACK- LIGHT COLORED GRAY/BLUE BRUISING SCATTERED, UNMEASURABLE, TENDERNESS TO TOUCH.	N0205		

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N0205	Continued from page 21 - ADDITION TO THE NOTED ABOVE BRUISING PATIENT ALSO HAS A BRUISE TO THE CENTER OF [HIS/HER] FOREHEAD MEASURING 2 X 1.5CM WITH A BUMP THAT PROTRUDES OUT; ALSO HAD A BRUISE TO LEFT ELBOW MEASURING 2.3 X 1.6 CM." On 06/16/2026, HRN Q documented a narrative note which read, in part: "PATIENT WAS SITTING WITH OTHER RESIDENTS IJ [sic] THE MAIN LIVING AREA ALONG WITH STAFF. STAFF STATED AT TIMES WITH MOVEMENT WHEN [S/HE] STARTS TO MOVE HAS SOME NOTED GRIMACING. ENCOURAGED PRN TYLENOL. HAD STAFF GIVE AT TIME OF VISIT. WALKED OUTSIDE WITH PATIENT AND GAIT WAS STEADY. WAS IN A PLEASANT MOOD. BRUISING REMAINS PRESENT AS NOTED BELOW…" On 06/17/2026, HSW M documented a narrative note which read, in part: "PRESENT FOR CARE CONFERENCE WAS [Person H], [Person K], [Person U] ([Family]/SECONDARY POAHC), [MCO CW P], [MCO CC L], [ED A], [WD B], [CC I], [MCD J], [Ombudsman SJ, [HSW R], AND WRITER. ALSO PRESENT VIA ZOOM WAS [APSW N]. THE FIRST TOPIC OF DISCUSSION WAS THE 30 DAY NOTICE, WHICH HAD BEEN RESCINDED. [ED A] STATED THAT THEY ARE ISSUING A NEW 30 DAY NOTICE AND PROCEEDED TO HAND THIS OUT TO [Person H], [Person K], AND [MCO CW P]. [Person H] QUESTIONED WHY THIS IS HAPPENING AS [S/HE] WAS TOLD EARLIER IN THE WEEK THAT THE FIRST NOTICE HAS BEEN RESCINDED AND FACILITY IS HAPPY THAT [Resident 1] WILL BE ABLE TO STAY. [ED A] STATED THAT WAS SOMETHING THAT CAME FROM THE FACILITY LEGAL TEAM… CONVERSATION THEN TURNED TO THE INCIDENT FROM EARLIER IN WEEK WHEN [Resident 1] WAS PHYSICALLY ASSAULTED BY ANOTHER RESIDENT. IT WAS LEARNED AT THIS TIME THAT THIS WAS THE SECOND INCIDENT BETWEEN [Resident 1] AND THIS RESIDENT, BOTH WHICH [Resident 1] WAS NOT THE AGGRESSOR. ON 5/29/2026 THIS SAME RESIDENT ENTERED [Resident I's] ROOM DURING THE NIGHT. [Resident 1] WAS SLEEPING IN [HIS/HER] BED, WAS STARTLED BY THIS PERSON COMING IN [HIS/HER] ROOM SO [S/HE] GOT OUT OF BED IN ATTEMPT TO GET [HIM/HER] TO LEAVE. [S/HE] THEN BECAME PHYSICAL WITH [Resident 1]. FAMILY DID NOT KNOW THIS WAS THE SECOND TIME WITH THE SAME PERSON. APS THEN BECAME VERY CRITICAL OF FACILITY AS RELATED TO POOR	N0205		

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N0205	Continued from page 22 NOTIFICATION OF POAHC, NO NOTIFICATION TO HOSPICE, SELF REPORT TO DQA OF INCIDENT (ALSO REQUESTING PROOF OF SELF REPORT BE EMAILED TO [HIM/HER]), LACK OF MEDICAL ATTENTION BY FACILITY INCLUDING OFFER TO GO TO ER. THERE WAS ALSO QUESTION RELATED TO THE PROVISION, OR LACK OF, DETAILS TO ALL PARTIES. FACILITY HAS HISTORY OF REFUSING TO PROVIDE INFORMATION TO ANYONE STATING 'THEY CAN'T GIVE THAT OUT'. WRITER DID COMMENT ON LACK OF NOTIFICATION OF HOSPICE RELATED TO THE ASSULT [sic]. WRITER STATED THAT HAD WE BEEN NOTIFIED OUR ON CALL NURSE WOULD HAVE RESPONDED IMMEDIATELY TO ASSESS INJURIES AND WOULD HAVE LIKELY RECOMMENDED TRIP TO ER FOR IMAGING TO ENSURE NO OTHER, UNSEEN, INJURIES PRESENT. IT SHOULD ALSO BE NOTED THAT [Person HJ WAS NOTIFIED VIA TEXT FROM STAFF WORKING TO ' CALL WHEN YOU GET THIS ' . APS THEN DISMISSED FACILITY FROM MEETING TO DISCUSS WITH FAMILY, [MCO], [hospice], AND OMBUDSMAN RELATED TO NEXT STEPS. [APSW N] STATED THAT [S/HE] HAS SIGNIFICANT CONCERNS RELATED TO [Resident I's] SAFETY. [S/HE] AGAIN REFERENCED THE VIDEO OF THE ASSULT [sic] NOTING IT WAS AGREGIOUS [sic] AND THE MOST VIOLENT AND AGGRESSIVE VIDEO [S/HE] HAS EVER WATCHED IN COURSE OF CAREER. TIMELINE OF EVENTS WAS DISCUSSED; 1219 (12:19 a.m.)- OTHER RESIDENT ENTERS ROOM. [Resident 1] WAS SITTING IN [HIS/HER] ROCKING CHAIR, ROCKING, AND GOT UP TO SEE WHO WAS COMING IN. 1220 (12:20 a.m.) ALTERCATION BEGAN. 1223 (12:23 a.m.) STAFF ENTERED ROOM. 1227 (12:27 a.m.) STAFF REVIEWED THE VIDEO. AGAIN, IT SHOULD BE NOTED THAT DESPITE HAVING REVIEWED THE VIDEO STAFF DID NOT PROVIDE ANY DETAILS TO [Person H] OR OFFER TO CALL EMS. [Person H] EXPRESSED GUILT THAT [S/HE] DIDN'T TAKE [Resident 1] IN RIGHT **AWAY.** TEAM PROVIDED REASSURANCE THAT IT WAS NOT UNTIL APS VIEWED THE VIDEO THAT ANYONE KNEW THE SERIOUSNESS OF WHAT HAD HAPPENED. ONCE KNOWN, [S/HE] DID ACT AND ENSURED THERE WAS NO UNSEEN SERIOUS INJURY." On 06/20/2026, HRN W documented a narrative note which read, in part: "PATIENT WAS FOUND SWEEPING FLOOR WITH BROOM, [Caregiver V], STAFF AT FACILITY, WATCHING PT (patient). PT TALKING NONSENSICAL. WRITER TALKED TO [Caregiver V] AT FACILITY, [Caregiver V], WOULD NOT UPDATE WRITER REGARDING BRUISES ON PATIENT'S RIGHT EYE, LEFT ARM AND BACK,	N0205		

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N0205	Continued from page 23 [Caregiver V] STATED UNABLE TO GIVE DETAILED REPORT, [Caregiver V] (SMILING/SMIRKING FACIAL EXPRESSIONS) ALSO, STATED [S/HE] HAS NO CONCERNS WITH PATIENT. WRITER WAS ABLE TO SIT PATIENT DOWN, PATIENT WAS PLEASANT, UNABLE TO MAKE NEEDS KNOWN ... BRUISING: RIGHT OUTER EYE - BRUISING WITH BLACK/YELLOWISH COLOR LEFT UPPER ARM RIGHT FOREARM LEFT FLANK/MID BACK CHECKED IN AND OUT WITH [Caregiver V] AT FACILITY." HOSPITAL RECORD The hospital record indicated Resident 1 arrived at the emergency department on 06/15/2026 at 5:04 p.m. The history of present illness read: "[Resident 1] is a [age] [fe/male] presenting to the ER today for assault that occurred last night at the memory care unit. Another resident it [sic] taken a cane and hit [him/her] several times. There is video footage of the incident. incident. Police [him/her] [sic] involved adult protective services also. They recommend family bring [him/her] to the ER for evaluation, head CT, documentation of the injuries also. [S/he] has injuries on [his/her] left upper arm, right forearm, head, buttock. Patient's [family] brought [him/her] to the ER for evaluation." The diagnoses listed from the visit were as follows: Traumatic ecchymosis (bruising) of eyebrow, right, initial encounter Traumatic ecchymosis of left upper arm, initial encounter	N0205		

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N0205	Continued from page 24 Traumatic ecchymosis of right forearm, initial encounter Traumatic ecchymosis of buttock, initial encounter Injury due to physical assault Dementia Facial abrasion Traumatic ecchymosis of elbow, left, initial encounter Resident 1 was discharged from the ER at 7:28 p.m. His/her condition was listed as stable. LAW ENFORCEMENT RECORD Surveyor reviewed the police report from Police Officer (PO) o. The report read: "On June 15, 2026 at about 12:02pm I [PO OJ heard a medical call dispatched to the Waterford in Colby at 1110 N Division St in the city of Colby, county of Marathon. The call stated an elderly resident needed to be sent out for evaluation and that [s/he] had struck a different resident earlier that morning. Around 12:35pm I arrived after being requested by the EMS crew on scene. The [fe/male] was later identified as [Resident 2]. While attempting to convince [him/her] to go with EMS staff members had mentioned that [s/he] had struck a [fe/male] resident overnight the previous night around midnight. They said [his/her] behavior was out of the ordinary and they suspected [s/he] had a urinary tract infection. [Resident 2] was eventually transported to the hospital via [his/her] [spouse] and POA. While leaving the parking lot I received a call from [APSW NJ. [APSW NJ said [s/he] had received a call from family members of [Resident 1] who was the resident that [Resident 2] had struck earlier that day. [APSW NJ said that [Resident 1] had received a black	N0205		

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N0205	Continued from page 25 eye and some lacerations to her arms with other minor bruising on [his/her] buttocks. [APSW NJ said that [s/he] was almost to the Waterford Facility to look into the allegations made to [him/her] that a serious assault had occurred and the victim was not sent to the hospital to be checked out. [APSW NJ] asked that I assist them while they interviewed staff about the incident. I stayed on scene and met them there. [APSW NJ and another member of APS spoke to various Waterford staff about the incident and the reasons for [Resident 1] not being sent out. At the time of our questioning, [Resident 1] was out of the facility eating out in Spencer, WI. It should be noted that both [Resident 1] and [Resident 2] resided in a locked portion of the facility set aside for persons with memory issues as both suffered from cognitive memory issues. Supervisory staff was not initially forthcoming with willingness to share any documentation regarding the incident but after speaking with their legal department, provided copies of all documentation requested by APS staff. We learned that there was video footage of the incident and were shown the incident in its entirety. The management staff member told us that the cameras are always recording but no physical recording is saved until a fall is picked up by the cameras sensors. If a camera detected a fall the recording would start a few minutes prior to the actual fall and save for some time afterwards. When a camera detected a fall it would also send an alert to the respective staff members work cell phone immediately so they could respond to the room. The video was played for us and you could see [Resident 1] sitting in a chair in [his/her] room. The door to [Resident I's] room was closed and in the video it opens and [Resident 2] enters the room. [Resident 1] got out of [his/her] chair and confronts [him/her] motioning with [his/her] hands for [him/her] to get out. [Resident 1] attempted to push [Resident 2] out of [his/her] room as [s/he] did not make any attempt to leave. Once pushed [Resident 2] begins pushing [Resident 1] and then grabbed near [his/her] shoulders. [Resident 2] walked further into [Resident I's] room pushing [him/her] backwards by [his/her] shoulders until reaching the far interior wall of the room. [Resident 2] gave a large push causing [Resident 1] to stumble backwards and fall hitting what appeared to me as a wall mounted AC (air conditioning) unit placed low to the ground similar to a hotel setup. [Resident 1] appeared to hit the object with the back of [his/her] neck. [Resident 2] sat down on [Resident I's] bed while [s/he] picked [him/herself] up from the floor at [his/her] feet. As	N0205		

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N0205	Continued from page 26 [Resident 1] got to [his/her] feet [s/he] grabbed a broom in a horizontal fashion. [Resident 2] grabbed across from where [Resident 1] was holding onto it and there was a struggle over the broom for a bit. [Resident 1] ended up on top of [Resident 2] on [his/her] bed struggling for the broom and [Resident 2] pushed [him/her] off causing [him/her] to fall back onto the AC like object in a seated position on top of it. [Resident 2] regained [his/her] upright seated position and struck [Resident 1] in the head with one end of the broom about 3 times before the broom head fell off. [Resident 2] struck [Resident 1] another 2 times with the stick portion of the broom and [Resident 1] was able to grab onto the handle again and finally wrestle it away from [Resident 2]. [Resident 1] hit [Resident 2] with the broom handle once while [s/he] was seated and before [s/he] could connect again [Resident 2] got up from the bed and grabbed [Resident 1] by the neck area. [Resident 2] pushed back against [him/her] forcefully that [s/he] appeared bent backwards over the AC like object. [Resident 2] continued that grip at times pushing harder into [Resident 1] with [his/her] hands near [his/her] neck area. [Resident 2] let go with one hand and appeared to strike [Resident 1] in the head and [s/he] moved [his/her] grip to [Resident I's] hair. [Resident 2] grabbed [his/her] hair with both hands and fell backwards onto [Resident I's] bed in a seated positions with [Resident 1] coming with [him/her] due to [his/her] hair being pulled. There was a brief lull where both parties were fighting for control of the others hands and [Resident 2] again grabbed for [Resident I's] hair. [Resident 2] pulled causing [Resident 1] to fall to [his/her] knees by the bed and another resident is seen entering the room. Seconds after a staff member entered the room and placed [him/herself] between [Resident 2] and [Resident 1]. [Resident 1] is assisted to [his/her] feet and out of [his/her] room where [Resident 2] stayed sitting on [his/her] bed for a bit alone in the room. [Resident 2] grabbed the broken broom stick and leaves the room ... See APS for exact video length and times. Waterford staff was asked why [Resident 1] was not sent out for medical evaluation and we were told that the POA for [Resident 1] was called. We were told the POA had came to the facility shortly after the incident and when asked if they wanted [Resident 1] sent out for evaluation they declined. [Resident 1] arrived after speaking with relevant staff and [APSW N] spoke to [him/her] about the incident and with how [s/he] was feeling. Staff said that [Resident 2] was not going to be allowed back to the facility due to [his/her] actions there. I later learned from family of [Resident I's] that they had received a 30 day eviction notice for [him/her] as well. I had dispatch check for all calls over the	N0205		

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N0205	Continued from page 27 previous night and there were no medical calls from the Waterford regarding this incident. Respectfully Submitted [POO]" APS RECORD Surveyor reviewed a report from APS titled: "At-Risk Investigation Closure Report" The report read, in part: "Type of Abuse: Physical abuse. Neglect Findings: Evidence shows that the Adult at Risk has been hurt or harmed Follow Up/Recommendations: Writer is closing this case as harmed as of 6/24/26, related to physical abuse and neglect substantiated through investigation. The client has been moved to an alternative setting, [name] on 6/24/26. APS fielded concerns 6/15/26 of physical abuse by ' an unknown individual ' at the time of the original report. Through investigation, the abuser was identified, and APS also identified neglect by the facility, as it is APS perspective neglect occurred from the facility given two times (5/29 & 6/16 [sic]) that the facility did not seek medical attention for [Resident 1] after [s/he] was physically assaulted nor did Waterford of [sic] Colby work with activated decision-maker to give details related to incidents that occurred. A DHS (Department of Health Services) report was filed on 6/16/26. LE (law enforcement) also has record of this investigation and information was provided to the APOA-HC (activated power of attorney for health care) that records could be obtained from **LE** for their further review." INTERVIEWS On 09/16/2026 at approximately 8:30 a.m., Surveyor interviewed Caregiver C on the phone. Caregiver C told Surveyor s/he no longer worked at the facility. Surveyor asked Caregiver C what s/he could	N0205		

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N0205	Continued from page 28 remember form the night Resident 2 and Resident 1 had an altercation. Caregiver C told Surveyor Resident 1 liked to walk around at night. S/he said when Resident 1 went to his/her room for the night. S/he did lock Resident I's door. Caregiver C said Resident 1 later came out of his/her room for a snack. Caregiver C said s/he was cleaning in the dining room and preparing for breakfast. Caregiver C explained Resident 1 went back to his/her room while Caregiver C finished up what s/he was doing. During that time another resident entered Resident I's room. Caregiver C said s/he heard the other resident yell for help and that is when s/he responded. Caregiver C said s/he placed him/herself between Resident 2 and Resident 1. Caregiver C said s/he called management but did not get an answer. Caregiver C saids/he got a hold of Resident I's POA and s/he came in to help calm Resident 1. Caregiver C told Surveyor that s/he "spaced out" calling EMS. On 09/16/2026 at approximately 9:00 a.m., Surveyor interviewed Person H on the phone. Person H was Resident I's activated power of attorney for healthcare. Surveyor asked about when Resident 1 was in an altercation with another resident. Person H said, "I was given no information." Person H explained to Surveyor that the staff member working knew I would come in if Resident 1 was having anxiety. Person H said s/he received a text message that said, "I really think [s/he] needs you, if you see this message can you call." Person H saids/he called and talked to the staff member that was working. Person H said s/he told the staff member to offer Resident 1 something sweet to eat and that would help to calm Resident 1 down. Person H told Surveyor that staff told him/her that there was a conflict and it was not Resident I's fault. Person H said when s/he came into the facility, the staff member told him/her s/he was glad s/he came in. Person H told Surveyor no management ever called me. Person H said they had a meeting set up with him/herself, management and APS. Person H said s/he looked at the management team and asked them when any of them were going to call him/her to talk to me about this. Person H said they all looked at the floor. Surveyor asked Person H if s/he was notified about the incident that happened prior to 06/15/2026 with another resident entering Resident I's room and an altercation. S/he said nobody told him/her about that altercation. Person H said staff would tell him/her, I can't tell you, if it involves another resident. Person H said staff would say, there were no injuries and that is all they would tell him/her. Person H talked to Surveyor more	N0205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 0015955	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT COLBY (THE)	**1110 N DIVISION ST, COLBY, Wisconsin, 54421**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
N0205	Continued from page 29 about the incident that occurred on 06/15/2026. Person H said the leg was busted on Resident I's chair. Person H said the staff member told him/her that Resident 1 suffered consequences from the dustpan and handle. Person H said Resident 1 did not remember what happened but Resident 1 would put his/her hand to his/her eye and say, "oh!" Person H said staff would not let him/her or Person K read Resident I's record. Person H told Surveyor the police had the video of the altercation. Person H said the police officer told him/her, trust me, you don't want to see that. Person H said they moved Resident 1 to a different facility. During the survey process from 09/09/2026 through 09/22/2026, Surveyor had email correspondences between Surveyor and the provider's management team. On 09/21/2026, Surveyor requested additional information. On 09/21/2026, ED A replied, via email, which read: "What information was provided when the incident occurred on 05/29/2026 and 06/15/2026 to [Resident I's] POA and hospice? On 5/29 Hospice was contacted via phone call by [Caregiver T] at the time of the incident. POA was also contacted by [Caregiver T] at the time of the incident. Per the incident report they were told of the altercation and that no apparent injury was noted at the time. On 6/15 Hospice was notified via in person (by [CC I]) and fruced with details of the incident on 6/15/26 by [WD B]. [Caregiver C] called the POA immediately after the incident. [WD B] documented she checked in with POA to see if any further information was requested on 6/15/26). Also, a care conference was scheduled to discuss the incident. Were they ever notified of the amount of times [Resident 1] was struck in the face and head for both of these incidents? Not that is documented by care staff or management, as there were no 1st hand witnesses of either incident. The altercation and any injuries were noted to both parties.	N0205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 0015955	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED 09/22/2026

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N0205	Continued from page 30 Has [Resident I's] POA ever requested to read [Resident I's] record since [Resident 1] resided at the facility? No, [s/he] has not." On 09/22/2026 at approximately 10:15 a.m., Surveyor interviewed Hospice Regional Director (HRD) X on the phone. Surveyor asked HRD X if the provider notified hospice when Resident 1 was in an altercation with another resident on 05/29/2026 and 06/15/2026, when Resident 1 received multiple blows to the head and face. HRD X told Surveyor that staff did call the hospice triage line on 05/29/2026. HRD X said triage was notified there was an altercation with no injuries on 05/29/2026. HRD X said if staff would have made it known that Resident 1 received multiple blows to the head and face, they would have triaged the call differently. HRD X said on 06/15/2026, hospice was notified by Resident I's POA of the altercation and his/her injuries. HRD X told Surveyor if staff would have told hospice the details, hospice would have sent Resident 1 to the emergency room like they did with the altercation that occurred on 06/15/2026. On 09/22/2026 at approximately 1:00 p.m., Surveyor interviewed ED A and AA E on the phone. Surveyor explained concerns that details, known to the provider, from the Safely you video of the altercations that occurred on 05/29/2026 and 06/15/2026, were not given to Resident I's care team including his/her POA, hospice and MCO. By withholding information on the mechanism of injury Resident 1 sustained on 05/29/2026 and 06/15/2026, placed Resident 1 at substantial risk for harm as s/he could have sustained a traumatic brain injury. ED A told Surveyor the video recordings were confidential. ED A told Surveyor they have done retraining with staff on immediate reporting to all parties when an incident occurs.	N0205		