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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 000	Initial Comments On 11/24/2025, with information gathered through 12/03/2025, Surveyors conducted 3 complaint investigations at Arbor Village in Peshtigo. Three (3) of 3 complaints were substantiated. As a result of the survey, 5 deficiencies were issued. Census: 9	N 000		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by:	N 404		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 404	Continued From page 1 Based on observation and interview, the provider did not have a physician, pharmacist, or RN (Registered Nurse) conduct an on-site review of the provider's medication administration and medication storage systems at least annually. Findings include: On 10/17/2025 and 10/27/2025, the Department received concerns regarding the facility's medication administration. On 11/24/2025, during an on-site visit, Surveyors found multiple concerns with the facility's medication administration and medication storage system. On 11/24/2025 at 10:45 AM, Surveyor requested the provider's report of the annual medication administration and storage system review for the last 2 years. Administrator A confirmed no annual on-site review of the medication administration and medication storage was conducted. Administrator A stated, "I can't find any review that was done. Our nurse, [Registered Nurse B] is never here and [s/he's] responsible for the medications." Cross Reference N0409 DHS 83.37(1)(i) Proof of Use Record Cross Reference N0410 DHS 83.37(1)(k) Medication Error of Adverse Reaction Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration Cross Reference N0432 DHS 83.38(1)(h) Medication Administration	N 404		
N 409	83.37(1)(j) Proof-of-use record.	N 409		

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N 409	Continued From page 2 Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the proof-of-use records for controlled substances administered were complete and accurate. Resident 5 received a schedule II medication. The resident's CDRR (Controlled Drug Receipt Record) also known as the proof-of-use record did not reflect the amount of medication present in the facility, each time the medication was given/removed from the inventory, or the administrator/designee signature of the daily audits. The facility is licensed to provide services for up to 50 residents who may be developmentally disabled, terminally ill, physically disabled, advanced aged, and/or have Alzheimer's/dementia. This is a repeat deficiency. See Statement of Deficiency (SOD) 2RZJ11, dated 07/22/2025. Findings include: According to	N 409		

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https://www.drugs.com/schedule-2-drugs.html updated 11/10/2025, "Schedule II drugs are a category of drugs considered to have a strong potential for abuse but have legitimate medical use. The following drugs are listed as Schedule 2 (II) Drugs by the Controlled Substances Act (CSA)...Morphine..."

On 10/17/2025 and 10/27/2025, the Department received concerns regarding the facility's medication administration.

On 11/24/2025, Surveyor reviewed Resident 5's medical record. The resident had a physician's order for morphine sulfate 5 mg (milligram)/0.25 ml (milliliter) pre-filled syringes to be given by mouth every 4 hours as needed for pain/shortness of breath.

On 11/24/2025 at 10:15 AM, Surveyor and Resident Assistant C counted Resident 5's morphine syringes and noted fourteen 5 mg/0.25 ml pre-filled syringes remained in the separately locked drawer within the medication cart. All fourteen morphine syringes were in a plastic bag with a pharmacy label attached to the outside. The pharmacy label indicated Resident 5's name, the type and dosage of the medication and directions for use. Additionally, the label indicated the pre-filled syringes were dispensed on 11/19/2025. Surveyor and Resident Assistant C then observed and reviewed two CDRR forms for Resident 5's morphine sulfate 5 mg/0.25 ml pre-filled syringes. The first form indicated the facility received 5 ml of morphine sulfate, which was dispensed in twenty 5 mg/0.25 ml pre-filled syringes on 11/10/2025 and the second CDRR form indicated the facility received 5 ml of morphine sulfate, which was dispensed in twenty 0.25 ml pre-filled syringes on 11/19/2025. Neither

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CDRR form showed the remaining balance of Resident 5's pre-filled morphine syringes. At the time of observation, Resident Assistant C confirmed the facility was not maintaining a daily accounting to reflect the remaining balance of Resident 5's pre-filled morphine syringes. In addition, Resident 5's CDRR forms documented the person administering the medication, but there were no signatures or dates to show daily audits of Resident 5's CDRR forms had been completed by the administrator/designee.

Surveyor reviewed Resident 5's November 2025 eMAR. The eMAR showed Resident 5 received the morphine sulfate 5 mg/0.25 ml pre-filled syringe twenty-two times from 11/10/2025 through 11/23/2025. Surveyor noted inconsistencies in documentation between Resident 5's November 2025 eMAR and Resident 5's CDRR forms dated 11/10/2025 and 11/19/2025. The CDRR forms did not include documentation the morphine sulfate 5 mg/0.25 ml pre-filled syringe was given or removed from Resident 5's inventory on the following dates and times:

*11/12/2025 at 4:01 PM
*11/13/2025 at 7:14 PM
*11/14/2025 at 7:25 AM
*11/14/2025 at 6:57 PM
*11/15/2025 at 3:34 AM
*11/15/2025 at 9:45 AM
*11/15/2025 at 1:45 PM
*11/15/2025 at 11:08 PM
*11/16/2025 at 8:30 AM
*11/17/2025 at 8:26 AM
*11/19/2025 at 1:03 PM
*11/20/2025 at 11:42 AM

On 12/02/2025 at 9:50 AM, Surveyor interviewed Pharmacist D regarding Resident 5's morphine

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sulfate 5 mg/0.25 ml pre-filled syringes. Pharmacist D verified the pharmacy sent the facility twenty (20) morphine sulfate 5 mg/0.25 ml pre-filled syringes on 11/10/2025 and an additional twenty (20) on 11/19/2025 for Resident 5.

***Surveyor noted the facility received a total of forty (40) morphine sulfate 5 mg/0.25 ml pre-filled syringes for Resident 5, twenty dispensed on 11/10/2025 and another twenty dispensed on 11/19/2025. Out of the forty (40) morphine sulfate 5 mg/0.25 ml pre-filled syringes only thirty-six (36) could be accounted for, fourteen (14) syringes remained in the locked drawer on the medication cart and twenty-two (22) were documented in the November 2025 eMAR as being administered.

On 11/24/2025 at 10:33 AM, Surveyor questioned Resident Assistant C regarding Resident 5's pre-filled morphine syringes and the discrepancies in the amount received from pharmacy versus the amount left in the plastic bag within the med cart. Resident Assistant C stated, "I'm not sure...The pharmacy often sends us twenty pre-filled syringes at a time." Surveyor then asked Resident Assistant C about the inconsistencies in documentation between Resident 5's November 2025 eMAR and CDRR forms. Resident Assistant C acknowledge Resident 5's November 2025 eMAR documented the morphine sulfate 5 mg/0.25 ml pre-filled syringe was given to Resident 5 twenty-two times from 11/10/2025 through 11/23/2025, but Resident 5's CDRR only revealed documentation for 9 out of the 22 times it was given.

On 11/24/2025 at 10:40 AM, Surveyor interview Administrator A regarding the above information

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N 409	Continued From page 6 for Resident 5. Administrator A confirmed Resident 5's CDRR forms did not include accurate counts, administration information, or daily audits.	N 409		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on interview and record review, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after 1 of 1 (Resident 5) residents reviewed refused a medication for 2 consecutive days. Resident 5 had an order for Tamsulosin 0.4mg(milligrams) take 1 capsule daily. Resident 5's November MAR (Medication Administration Record) indicated Resident 5 refused the medication from 11/12/2025 through 11/23/2025. Resident 5's record did not contain	N 410		

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documentation Resident 5's physician, supervising nurse or a pharmacist was notified Resident 5 had refused the medication 12 consecutive days.

Findings Include:

On 10/27/2025, the department received a complaint regarding medication administration.

On 11/24/2025, Surveyors conducted an onsite visit to the facility and a sample of residents was reviewed, including the record of Resident 1.

Resident 5 had an order for Tamsulosin 0.4mg(milligrams) take 1 capsule daily. Resident 5's November MAR indicated Resident 5 refused the medication from 11/12/2025 through 11/23/2025. Resident 5's record did not contain documentation Resident 5's physician, supervising nurse or a pharmacist was notified Resident 5 had refused the medication 12 consecutive days.

On 11/24/2025 at 10:00 AM, Surveyor observed the medication cart with Resident Assistant C. Surveyor observed Resident 5's Tamsulosin pill in the bubble pack for 11/13/2025 through 11/23/2025. Resident Assistant C stated Resident 5 has been refusing Tamsulosin daily. Resident Assistant C stated s/he has not notified Resident 5's physician, nurse or pharmacist of any refusals.

On 11/24/2025 at approximately 2:30 PM, Surveyor interviewed Administrator A. Administrator A verified Resident 5's November MAR indicated Resident 5 refused Tamsulosin for 12 consecutive days. Administrator A stated Resident 5 has a primary physician in Marinette

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N 410	Continued From page 8 but does not physically see the physician because Resident 5 is on hospice. Administrator A indicated primary physician nor hospice have been notified Resident 5 has refused Tamsulosin for 12 consecutive days.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at the time of medication administration and/or treatments, staff administering medication and/or treatments documented the date and time and initialed the resident's medication administration record. Residents' 1, 2, 3, 4, 5 and 6, October 2025 and November 2025 eMARs (electronic Medication Administration Records) did not reflect documentation for prescribed medications to indicate any of the following: -- If the resident received the medication, -- If the resident refused the medication,	N 415		

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N 415	Continued From page 9 -- If the medication supply was unavailable, -- If the resident was unavailable at the time medication administration was scheduled, and -- If the medication was being held for some other reason. Additionally, Resident 2's October 2025 eMAR did not reflect documentation to indicate if eye treatments were performed. Findings include: On 10/17/2025 and again on 10/27/2025, the Department received concerns regarding the facility's medication administration. Resident 1 On 11/24/2025, Surveyor conducted a review of Resident 1's closed medical record which revealed the following physician's orders: *Risperidone 1.5 mg tablet twice daily at 8 AM and 8 PM *Citalopram 40 mg tablet daily at 8 AM *Polyethylene Glycol powder 8.5-17 grams mixed in liquid every other day *Docusate Sodium Capsule 100 mg tablet daily at 8 PM *Trazodone 100 mg tablet daily at 8 PM *Daily-Vite one tablet daily at 4 AM *Vitamin D3 50 mcg one, give one capsule daily at 8 AM *Dalfampridin 10 mg, given one tablet twice daily at 8 AM and 8 PM *Spironolactone 25 mg tablet, give one tablet daily 8 AM *Fluticasone spray 50 mcg, instill 2 sprays each nostril daily at 8 AM *Bupropn HCL 300 mg XL tablet, give one tablet	N 415		

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daily at 8 AM
*Divalprox 250 mg tablet twice daily ay 8 AM and 8 PM
*Zyrtec 10 mg tablet daily at 8 AM
*Carbamide Peroxide 6.5%, place two drops in each ear daily at 8 AM

On 11/24/2025, Surveyor conducted a review of Resident 1's October 2025 eMAR. The following dates and times were not initialed by staff administering the medications:

*10/02/2025- 8 AM dose of Risperidone, Citalopram, Vitamin D3, Dalfampridin, Spironolactone, Fluticasone spray, Bupropn, Divalprox, Zyrtec and Carbamide Peroxide 6.5% eye drops
*10/11/2025- 4 PM dose of Daily-Vite tablet
*10/11/2025- 8 PM dose of Risperidone, Docusate Sodium, Trazodone, Dalfampridin and Divalprox
*10/15/2025- 8 AM dose of Risperidone, Citalopram, Vitamin D3, Dalfampridin, Spironolactone, Fluticasone spray, Bupropn, Divalprox, Zyrtec, Polyethylene Glycol powder and Carbamide Peroxide 6.5% eye drops

On 11/24/2025 at approximately 3 PM, Surveyors interviewed Administrator A regarding the above missing initials found on Resident 1's October 2025 eMAR. Administrator A confirmed Resident 1 was discharged from the facility late morning on 10/15/2025 and should have received all 8 AM medications prior to her/his departure. Administrator A stated, "I can't say if the medications were or were not administered on the above dates...Because staff didn't sign out if the medications were administered in the eMAR."

Resident 2

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N 415	Continued From page 11 On 11/24/2025, Surveyor conducted a review of Resident 2's medical record which revealed the following physician's orders and treatments: *Rosuvastatin 40 mg tablet daily at 8 PM *Hydroxyzine HCL 25 mg tablet daily at 8 PM *Trazodone 300 mg tablet daily at 8 PM *Topiramate 25 mg tablet twice daily at 8 AM and 4 PM *Senexon-S 8.6-50 mg tablet daily at 8 AM *Olopatadine Drops- one drop in both eyes twice daily at 8 AM and 8 PM *Clozapine 200 mg tablet three times daily at 8 AM, 4 PM and 8 PM *Gemfibrozil 600 mg tablet twice daily at 8 AM and 4 PM *Restasis 0.05%, place one drop in both eyes daily at 8 AM and 8 PM *Debrox Solution 6.5%, instill five drops in both ears daily at 8 PM *Mirtazapine 15 mg daily at 8 PM *Lid Scrubs daily at 8:30 AM *Warm Moist Compress to both eyes daily at 8 AM On 11/24/2025, Surveyor conducted a review of Resident 2's October 2025 and November 2025 eMAR. The following dates and times were not initialed by staff administering the following medications and/or treatments: *10/11/2025- 4 PM dose of Topiramate, Clozapine, Gemfibrozil *10/11/2025- 8 PM dose of Rosuvastatin, Hydroxyzine HCL, Trazodone, Olopatadine Drops, Clozapine, Restasis drops, Debrox ear drops and Mirtazapine. *10/18/2025- 8 AM treatment for Warm Moist Compress to both eyes	N 415		

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N 415	Continued From page 12 *10/18/2025- 8:30 AM treatment for Lid Scrubs *11/01/2025 and 11/02/2025- 8 AM treatment for Warm Moist Compress to both eyes *11/01/2025 and 11/02/2025- 8:30 AM treatment for Lid scrubs *11/16/2025- 8 PM dose of Clozapine and Debrox ear drops Resident 3 On 11/24/2025, Surveyor conducted a review of Resident 3's medical record which revealed the following physician's orders: *Quetiapine 25 mg tablet daily at 8 PM *Atorvastatin 20 mg tablet daily at 8 PM *Eliquis 5 mg tablet daily at 8 PM *Symbicort inhaler, 2 puffs twice daily at 8 AM and 8 PM *Divalproex 125 mg capsule twice daily at 8 Am and 8 PM On 11/24/2025, Surveyor conducted a review of Resident 3's October 2025 eMAR. The following date and time was not initialed by staff administering the medications: *10/11/2025- 8 PM dose of Quetiapine, Atorvastatin, Eliquis, Symbicort inhaler and Divalproex. Resident 4 On 11/24/2025, Surveyor conducted a review of Resident 4's medical record which revealed the following physician's orders: *Donepezil 10 mg tablet daily at 8 PM *Lamotrigine 25 mg tablet daily at 8 PM *Melatonin 3 mg tablet daily at 8 PM	N 415		

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N 415	Continued From page 13 *Olanzapine 10 mg tablet twice daily at 8 AM and 8 PM *Sertraline 50 mg tablet twice daily at 8 AM and 8 PM *Simvastatin 20 mg tablet daily at 8 PM *Trazodone 75 mg tablet daily at 8 PM On 11/24/2025, Surveyor conducted a review of Resident 4's October 2025 eMAR. The following date and time was not initialed by staff administering the medications: *10/11/2025- 8 PM dose of Donepezil, Lamotrigine, Melatonin, Olanzapine, Sertraline, Simvastatin and Trazodone. Resident 5 On 11/24/2025, Surveyor conducted a review of Resident 5's medical record which revealed the following physician's orders: *MS Contin 15mg take 15mg three times daily at 6 AM, 2 PM and 10 PM (discontinued 11/12/2025) *Dexamethasone 2mg take 1 tablet in the morning (8 AM) and 1 tablet at noon (12 PM) (discontinued 10/14/2025) *Melatonin 5mg take 1 tablet by mouth every night On 11/24/2025, Surveyor conducted a review of Resident 5's October and November 2025 eMAR. The following dates and times were not initialed by staff administering the medications: *10/06/2025 - 6 AM dose of MS Contin *10/07/2025 - 6 AM and 10 PM dose of MS Contin *10/11/2025 - 2 PM dose of MS Contin and 12 PM dose of Dexamethasone	N 415		

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N 415	Continued From page 14 *10/12/2025 - 10 PM dose of MS Contin *10/13/2025 - 6 AM dose of MS Contin *10/14/2025 - 6 AM and 2 PM dose of MS Contin *10/15/2025 - 6 AM dose of MS Contin *10/19/2025 - 6 AM dose of MS Contin *10/20/2025 - 6 AM and 10 PM dose of MS Contin *10/21/2025 - 6 AM dose of MS Contin *10/24/2025 - 6 AM dose of MS Contin *10/27/2025 - 6 AM and 10 PM dose of MS Contin *10/28/2025 - 6 AM and 10 PM dose of MS Contin *10/29/2025 - 6 AM dose of MS Contin *10/30/2025 - 6 AM and 10 PM dose of MS Contin *10/31/2025 - 6 AM dose of MS Contin *11/01/2025 - 6 AM dose of MS Contin *11/02/2025 - 6 AM and 10 PM dose of MS Contin *11/03/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/04/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/05/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/06/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/07/2025 - 6 AM and 10 PM dose of MS Contin *11/08/2025 - 6 AM and 10 PM dose of MS Contin *11/09/2025 - 6 AM and 10 PM dose of MS Contin *11/10/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/11/2025 - 6 AM, 2 PM and 10 PM doses of MS Contin *11/12/2025 - 6 AM and 2 PM doses of MS Contin *11/19/2025 - 8 PM dose of Melatonin	N 415		

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N 415	Continued From page 15 Resident 6 On 11/24/2025, Surveyor conducted a review of Resident 6's medical record which revealed the following physician's orders: *Lamotrigine 100 mg tablet take 1 tablet twice daily at 8 AM and 8 PM *Rosuvastatin 5mg tablet take 1 tablet by mouth at bedtime 8 PM *Mirtazapine 15mg tablet take 1 tablet by mouth at bedtime 8 PM *Donepezil 10mg tablet take 1 tablet by mouth at bedtime 8 PM *Pregabalin 75mg capsule take 1 capsule by mouth twice daily at 8 AM and 8 PM *Duloxetine 30mg capsule take 1 capsule by mouth at bedtime 8 PM *Doxepin 3mg tablet take 1 tablet every night at bedtime 8 PM On 11/24/2025, Surveyor conducted a review of Resident 6's October 2025 eMAR. The following date and time was not initialed by staff administering the medications: *10/11/2025- 8 PM dose of Lamotrigine, Rosuvastatin, Mirtazapine, Donepezil, Pregabalin, Duloxetine and Doxepin On 11/24/2025 at approximately 3 PM, Surveyors interviewed Administrator A regarding the above missing initials found on the above eMARs for Resident 2, 3, 4, 5 and 6. Administrator A verified the above dates and times on the above eMARs were not initialed by staff and stated, "I can't say if the medications were or were not administered on the above dates...Because staff didn't sign out if the medications or treatments	N 415		

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N 415	Continued From page 16 were administered in the eMAR."	N 415		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observations, interview and record review, the provider did not provide or arrange services adequate to meet the medication needs of residents. In 1 of 1 medication cart of the facility Surveyor discovered: *Opened bottles of eye drops for Resident 2 and Resident 8 without a date to indicate when the bottles were opened or expired *A small clear plastic bag with nine different unidentified pills labeled A.M. The pills were loose in the bag and not labeled with a resident's name or pharmacy label. *An opened bottle of acetaminophen 500 mg caplets. The bottle was not labeled with a resident's name or pharmacy label. Resident 2 did not receive his/her prescribed	N 432		

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topiramate or gemfibrozil during the 4 PM medication pass on 11/22/2025 as both medications remained in the blister pack card, and both medications were not charted as given. In addition, Resident 2 had a physician's order for olopatadine eye drops twice daily. Resident 2 did not receive the olopatadine eye drops as ordered.

Resident 3 did not receive his/her prescribed sertraline during the 8 AM medication pass on 11/24/2025 as the medication remained in the blister pack card, even though the medication pass was charted as given. In addition, Resident 3 had a physician's order for symbicort inhaler twice daily. Resident 3 did not receive the symbicort inhaler as ordered.

Resident 4 had physician's orders for lamotrigine daily and olanzapine twice daily. Resident 4 did not receive the lamotrigine or olanzapine medication as ordered.

Resident 5 was prescribed MS Contin 15 mg to be taken three times a day. Resident 5's physician discontinued the medication on 11/12/2025. Resident 5 received the medication once on 11/18/2025 and twice on 11/24/2025.

Resident 7's October 2025 MAR (Medication Administration Record) indicated Resident 7 did not receive 1 medication at 8 PM on 10/12/2025 and 9 medications at 8 AM on 10/13/2025. The reason given as not received on the MAR stated, "pharmacy did not yet deliver waiting on Dr [doctor] script" or "didn't get from pharmacy." Resident 7's record did not contain current physician orders to refill the prescriptions timely.

Findings Include:

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N 432	Continued From page 18 On 10/17/2025 and 10/27/2025, the Department received complaints regarding the facility's medication administration. According to https://www.inotekcorp.com/complete-guide-to-pataday-eye-drops-usage-expiration-and-more.html, last updated 09/12/2024 indicated, "Pataday eye drops contain an active ingredient called olopatadine...According to the manufacturer's instructions, Pataday eye drops typically have a shelf life of about 28 days once the bottle is opened. This means that after opening the bottle, the eye drops should be discarded after 28 days, even if there is still some medication left..." According to https://www.bausch.com/contentassets/2914df881e4344a7a202cc5a0673c977/latanoprost-ophthalmic-solution.pdf, revised 12/2020, "Once a bottle of latanoprost is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks..." On 11/24/2025 at 9:50 AM, Surveyor and Resident Assistant C observed the facility had one medication cart and the following was noted within the medication cart: *The top drawer of the medication cart contained an opened olopatadine 0.1% eye drop bottle for Resident 2 and an opened latanoprost 0.005% eye drop bottle for Resident 8. Both eye drop bottles were opened and contained no dates to confirm when the bottles were opened or expired. Resident Assistant C verified the bottle of olopatadine eye drops was opened and prescribed for Resident 2 and the bottle of latanoprost eye drops was opened and prescribed for Resident 8. Resident Assistant C	N 432		

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stated, "I've never been told to write an opened or expired date on the eye drop bottles when they're opened."

*The middle drawer of the medication cart contained a small clear plastic bag with nine different unidentified pills labeled "A.M." The pills were loose in the bag and not labeled with a resident's name or pharmacy label. Resident Assistant C indicated the pills were punched out of Resident 4's pharmacy unit dose blister packs and placed in the small plastic bag to be sent with Resident 4 during her/his family visit. Resident Assistant C verified Resident 4 had already left the facility for the visit and the pills labeled "A.M." were not sent along.

*The bottom drawer of the medication cart contained an opened bottle of acetaminophen 500 mg caplets. The bottle was not labeled with a resident's name or pharmacy label. Resident Assistant C acknowledged the bottle of acetaminophen was not labeled with a resident's name or pharmacy label and stated, the bottle of Acetaminophen is used as the "House Stock" for the residents.

Resident 2

On 11/24/2025 at approximately 9:45 AM, Surveyor observed the medication cart with Resident Assistant C. Resident Assistant C explained medications were dispensed by correlating the date of the month with the matching number on the blister pack card. After the medication is punched out and administered, staff initial the eMAR (electronic medication administration record), within ECP. Surveyor observed Resident 2's topiramate four (4) PM blister pack card and noticed an extra dose

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remained in the card for 11/22/2025. Surveyor then observed Resident 2's gemfibrozil four (4) PM blister pack card and noticed an extra dose remained in the card for 11/22/2025. Resident Assistant C acknowledged the observation and verified Resident 2's four (4) PM dose of topiramate, and gemfibrozil medication were not given on 11/22/2025. Resident Assistant C and Surveyor then used the facility's eMAR, to verify the charting. Surveyor and Resident Assistant C found there was no documentation the dose of the topiramate, or gemfibrozil medication was given at 4 PM on 11/22/2025.

On 11/24/2025, Surveyor reviewed Resident 2's record which indicated, the resident was admitted to the facility on 10/08/2019 with diagnosis to include bipolar disorder, hyperlipidemia and anxiety. Additionally, the facility managed and administered all of Resident 2's medication. Resident 2 had physician's orders for, "Topiramate 25 mg tablet by mouth twice daily, gemfibrozil 600 mg tablet twice daily and olopatadine eye drops 0.01%, one drop in both eyes twice daily."

On 11/24/2025, Surveyor reviewed Resident 2's October 2025 eMAR which revealed Resident 2 did not receive his/her olopatadine eye drops at 8 PM on 10/15/2025 and 10/16/2025 because the medication was "Not in/Not here." Resident 2's November 2025 eMAR revealed Resident 2 did not receive her/his olopatadine eye drops at 8 PM on 11/3/2025, 11/04/2025, 11/06/2025 and on 11/07/2025 because the facility was "Waiting on new prescription/pharmacy."

On 11/24/2025 at approximately 3:00 PM, Surveyors discussed the above observations of Resident 2's medication remaining in the blister

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packs and not being documented as given with Administrator A. Surveyor also shared Resident 2's eye drop medication was not administered on the above dates due to the above documented reason(s). Administrator A acknowledged Surveyor's observation and Resident 2's October 2025 and November 2025 eMAR documentation. Administrator A indicated a former staff member was not re-ordering medications timely.

Resident 3

On 11/24/2025 at approximately 9:45 AM, Surveyor observed the medication cart with Resident Assistant C. Surveyor observed Resident 3's eight (8) AM sertraline blister pack card and noticed an extra dose remained in the card for 11/24/2025. Resident Assistant C acknowledged the observation and verified Resident 3's eight (8) AM sertraline medication was not given on 11/24/2025. Resident Assistant C verified the medication was documented as being administered in Resident 3's eMAR, but the medication remained in the blister pack. Resident Assistant C stated, "I thought I gave it."

On 11/24/2025, Surveyor reviewed Resident 3's record which indicated, the resident was admitted to the facility on 02/27/2025 with diagnosis to include depression and chronic obstructive pulmonary disease. Additionally, the facility managed and administered all of Resident 3's medication. Resident 3 had physician's orders for, "Sertraline 25 mg tablet by mouth daily at 8 AM and symbicort inhaler two puffs twice daily (8 AM and 8 PM)."

On 11/24/2025, Surveyor reviewed Resident 3's October 2025 eMAR which revealed Resident 3 did not receive his/her symbicort inhaler at 8 PM

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on 10/21/2025 and 8 AM on 10/22/2025 because the facility was "waiting on refill/waiting on pharmacy to deliver."

On 11/24/2025 at approximately 3:00 PM, Surveyors discussed the above observation of Resident 3's sertraline medication remaining in the blister pack and being documented as given with Administrator A. Surveyor also shared Resident 3's symbicort inhaler medication was not administered on the above dates due to the above documented reason(s). Administrator A acknowledged Surveyor's observation and Resident 3's October 2025 eMAR documentation. Administrator A indicated a former staff member was not re-ordering medications timely.

Resident 4

On 11/24/2025, Surveyor reviewed Resident 4's record which indicated, the resident was admitted to the facility on 04/16/2025 with diagnosis to include schizoaffective disorder, anxiety and paranoid personality disorder. Additionally, the facility managed and administered all of Resident 4's medication. Resident 4 had physician's orders for, "Lamotrigine 25 mg tablet by mouth daily at 8 PM and olanzapine 10 mg twice daily (8 AM and 8 PM)."

On 11/24/2025, Surveyor reviewed Resident 4's October 2025 eMAR which revealed Resident 4 did not receive his/her lamotrigine medication at 8 PM from 10/18/2025 through 10/29/2025, twelve (12) consecutive days because the facility was "waiting on refill/waiting on pharmacy." Additionally, the eMAR revealed Resident 4 did not receive his/her olanzapine medication at 8 PM on 10/09/2025, 10/13/2025, 10/14/2025, 10/15/2025 and 10/16/2025 because the facility

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was "waiting on refill/waiting on pharmacy."

On 11/24/2025 at approximately 3:00 PM, Surveyors discussed with Administrator A, Resident 4's lamotrigine and olanzapine medication were not being administered on the above dates due to the above documented reason(s). Administrator A acknowledged Resident 4's October 2025 eMAR documentation. Administrator A indicated, a former staff member was not re-ordering medications timely and then stated, "We did request refills from the pharmacy for [Resident 4's] lamotrigine, but we never received the medication." Surveyor asked Administrator A to provide evidence of the facility's attempts to obtain the lamotrigine medication. On 11/25/2025 Administrator A sent Surveyor a "Medication Reorder" form dated 03/03/2025 indicating Resident 4's name and lamotrigine 25 on the form. Surveyor noted the refill was requested during the month of March 2025 and the lamotrigine medication refill in question was for the month October 2025. No other evidence was provided.

On 12/02/2025 at 9:50 AM, Surveyor interviewed Pharmacist D regarding Resident 4's lamotrigine medication for October 2025. Pharmacist D indicated on 10/08/2025 the pharmacy was only able to dispensed ten (10) tablets of Resident 4's lamotrigine medication because the resident's lamotrigine prescription had expired. Pharmacist D stated, "On 10/08/2025, we sent communication to the facility as a hard copy note and fax indicating the reason [Resident 4's] full cycle fill of lamotrigine medication was missing because we needed a new valid prescription. On 10/02/2025, we requested a new valid prescription from [Resident 4's] provider, but were told the provider will not prescribe. On

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N 432	Continued From page 24 10/02/2025, the facility and us (the pharmacy) received a letter indicating the renewal of [Resident 4's] lamotrigine medication was denied from the previous provider." Pharmacist D stated, "We couldn't send anymore lamotrigine medication tablets because we never received a new valid prescription. On 10/29/2025, we received a new valid prescription for [Resident 4's] lamotrigine medication and we were able to fill the lamotrigine medication for the prescribed amount of days." Resident 4 did not receive the lamotrigine medication from 10/18/2025 through 10/29/2025, because the facility did not ensure Resident 4 had a new valid prescription for the lamotrigine medication prior to the old prescription expiring. Resident 5 On 11/24/2025, Surveyor conducted a review of Resident 5's medical record. Resident 5 was admitted to the facility on 04/08/2025 with the following diagnoses, emphysema, chronic obstructive pulmonary disease and benign prostatic hyperplasia without lower urinary tract symptoms. Resident 5 was admitted to hospice on 10/24/2025. Resident 5's record indicated the following physician orders: *MS Contin 15 mg to take 15 mg three times daily at 6 AM, 2 PM, and 10 PM On 11/24/2025, Surveyor reviewed Resident 5's eMAR. Surveyor noted Resident 5 received MS Contin on 11/18/2025 at 10 PM medication pass and on 11/24/2025 at 6 AM medication pass and 2 PM medication pass. On 11/26/2025 at 8:49 AM, Surveyor sent	N 432		

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Administrator A an email asking him/her to clarify Resident 5's MS Contin orders.

On 11/27/2025 at 1:27 PM, Administrator A replied to the email stating, "Yes the MS contin is discontinued. I'll send that [discontinue order] today..." Surveyor did not receive any additional information.

On 12/01/2025 at 12:35 PM, Surveyor received another email from Administrator A stating, "[Resident 5] is going back on MS contin its supposed to be here today. Would you like the new order when I receive it?"

On 12/01/2025 at 1:07 PM, Surveyor replied to via email to Administrator A indicating the Surveyor needed the discontinue order for the original order for MS Contin and the new order by the end of the day.

On 12/02/2025 at 8:15 AM, Surveyor interviewed Administrator A. Administrator A stated s/he was going to call hospice right away this morning to get the discontinue order for the MS Contin. Administrator A indicated Resident 5 was no longer prescribed the medication because hospice had decided to prescribe liquid morphine as an as needed medication. Administrator A was unsure of the exact date.

On 12/02/2025 at 9:00 AM, Surveyor interviewed Hospice RN (Registered Nurse) F. Hospice RN F verified s/he was familiar with Resident 5. Hospice RN F stated Resident 5 has been with the hospice agency since 10/24/2025. Hospice RN F indicated Resident 5 had an order for MS Contin 15 mg to take 15 mg three times daily which started on 10/24/2025 and was discontinued on 11/12/2025 by Resident 5's

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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)	(X5) COMPLETE DATE
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physician. Hospice RN F stated the hospice agency faxed the facility the discontinued order on 11/12/2025 after 5:30 PM. Hospice RN F stated Resident 5 should not have received MS Contin after 11/12/2025.

On 12/02/2025 at 2:25 PM, Surveyor emailed Administrator A. Surveyor informed Administrator A that s/he was able to connect with hospice and was informed the discontinue date was 11/12/2025. Surveyor informed Administrator A that the eMAR had indicated Resident 5 received the medication on 11/18/2025 and 11/24/2025, several days after the discontinue order.

On 12/02/2025 at 3:58 PM, Administrator A replied via email to Surveyor indicating s/he would look into the medication situation.

On 12/03/2025 at 10:20 AM, Administrator A sent a text to Surveyor indicating the medication was not destroyed until 11/26/2025. Administrator A indicated staff were "probably not paying attention" to the orders and administered the medication.

On 12/03/2025, Administrator A provided Surveyor with a facility policy titled, "Medication Disposal/Destruction/Return to Pharmacy" with a date of 04/11/2025. The policy stated, "Medications are disposed of for a variety of reasons in a CBRF [Community Based Residential Facility] including: Resident discharge or death, discontinuation of medication, expired medications, omission...Medication that is not able to be returned to the pharmacy needs to be separated from other medications currently in use and must be stored in a locked area. The [sic] must be put into a container that is labeled Medication Destruction. Putting the medications

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in the Destruction box immediately will prevent medication errors. If a medication is discontinued but is left with the individuals current medications it may be administered by mistake."

Resident 7

On 11/24/2025, Surveyor conducted a review of Resident 7's closed medical record. Resident 7 was admitted to the facility on 09/12/2025 with the following diagnoses, cerebral infarction, iron deficiency anemia, hyperlipidemia, hemiplegia and hemiparesis on right dominant side, heart disease and agoraphobia with panic disorder. Resident 7's record indicated the following physician's orders:

*Melatonin 10mg (milligrams) tablet take 1 tablet every evening at 8 PM
*Acetaminophen 650mg take 650mg 4 times daily at 8 AM, 12 PM, 4 PM, 8 PM
*Acidophilus Capsule take one capsule twice daily at 8 AM and 4 PM
*Eliquis 5mg take 5mg twice daily at 8 AM and 4 PM
*Fluvoxamine 50mg take 50mg twice daily at 8 AM and 4 PM
*Jardiance 25mg take 25mg daily at 8 AM
*Loperamide 2mg take 2mg three times daily at 8 AM, 12 PM and 4 PM
*Olanzapine 2.5mg take 2.5mg twice daily at 8 AM and 4 PM
*Pantoprazole 40mg take 40mg every morning at 8 AM
*Vitamin D3 1,000 units take 1,000 units every morning at 8 AM

On 11/24/2025, Surveyor conducted a review of Resident 7's October 2025 eMAR. The following dates and times were marked "other" with staff

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initials. Staff then noted on MAR the meaning of "other" was "pharmacy did not yet deliver. waiting on Dr (physician) script" or "didn't get [medication] from pharmacy."

*10/12/2025 - 8 PM dose of Melatonin
*10/13/2025 - 8AM dose of Acetaminophen, Acidophilus Capsule, Eliquis, Fluvoxamine, Jardiance, Loperamide, Olanzapine, Pantoprazole and Vitamin D3.

On 11/24/2025 at approximately 3 PM, Surveyors interviewed Administrator A. Administrator A stated Resident 7 discharged from the facility on 10/13/2025 in the late morning. Administrator A stated Resident 7 received all his/her morning medications that were in the facility. Administrator A stated Resident 7's previous physician would not refill the medications because Resident 7 was not a patient of the physician any longer. Administrator A stated s/he contacted the pharmacy and the pharmacy stated they could not refill because there was no current physician order. Administrator A stated s/he then called the clinic in neighboring city to get Resident 7 set up with a physician in the clinic. Administrator A stated the soonest they could get Resident 7 in was 10/22/2025. Administrator A verified Resident 7 did not get the 1 medication on 10/12/2025 and the 9 medications on 10/13/2025 because the facility did not have current physician orders for refills.

On 11/26/2025 at 10:40 AM, Surveyor interviewed Pharmacist D. Pharmacist D verified s/he works for the pharmacy that contracts with the facility. Pharmacist D stated the pharmacy sent refill requests to Resident 7's previous physician on 10/13/2025. Pharmacist D stated the previous physician would not refill them because Resident

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N 432	Continued From page 29 7 was no longer a patient with the physician. Pharmacist D indicated the facility then asked to have the pharmacy contact a physician at the clinic in the neighboring city. Pharmacist D stated they did this but that physician would not fill the orders either because Resident 7 had not been seen by that physician yet. Pharmacist D stated the medications were not refilled and sent to the facility because there was no prescribing physician during this window of time.	N 432		