STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ARBOR VIEW COMMUNITIES	**34201 ARBOR LN BURLINGTON, WI 53105**

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N 000	Initial Comments On 07/10/2025, with information gathered through 07/25/2025, Surveyor conducted a standard licensure survey, a verification visit and 2 complaint investigations. Two deficiencies were identified. One of 2 deficiencies was a repeat violation (see Statement of Deficiency (SOD) VRL411). One of 2 complaints was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 43	N 000		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician	N 431		

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

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or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident received appropriate health monitoring to meet his/her needs. The provider did not make arrangements for 1 of 1 resident's physical health. The provider did not document communication with the resident's physician and other health care providers.

This is a repeat deficiency. See Statement of Deficiency (SOD) VRL411, dated 01/28/2021.

Resident 5's International Normalized Ratio (INR) levels were not monitored when s/he was prescribed Warfarin (blood thinner).

Findings include:

On 06/04/2025, the department received a concern that resident's medications were not being monitored.

On 07/10/2025, Surveyor reviewed Resident 5's record.

Resident 5 moved into the facility, 10/04/2024, with diagnoses including acute chronic congestive heart failure and unspecified atrial fibrillation.

Resident 5's pre-admission health exam, dated

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N 431	Continued From page 2 10/04/2024, documented: "Your medications have changed. Start Taking Warfarin (Coumadin [blood thinner]). You will need a blood test regularly to check on how the medication is working and if the dose is right for you." Resident 5's progress notes documented: 05/23/2025 - Resident has an appointment on Monday 06/02/2025. S/he will be picked up at 6AM. 06/03/2025 - This writer was notified via telephone call from Nurse at [medical facility name] that a clot was found in resident's leg. POA (power of attorney) was notified, and resident was picked up from the community by POA and brought to the emergency dept (department) for treatment. [Nurse Practitioner M] was notified. On 07/10/2025, at approximately 2:30 PM, Surveyor interviewed Administrator A and Nurse B. Surveyor asked for clarification as to who was responsible for monitoring Resident 5's INR levels. Nurse B explained that a traveling lab used to come to the facility and complete any requested lab draws. Nurse B stated the company was no longer offering traveling services and that there were months where lab tests could not be completed in the facility. Surveyor requested Resident 5's INR requests and completed tests for 2025. Surveyor was provided with documentation that stated: "06/16/2025 - Lab order for INR 06/23/2025. Prescribed by Nurse Practitioner (NP) M." Labs were completed. "06/24/2025 - Lab order for INR 07/01/2025. Prescribed by Nurse Practitioner (NP) M." Labs were completed.	N 431		

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N 431	Continued From page 3 On 07/15/2025, at approximately 4:15 PM, Surveyor interviewed NP M. Surveyor asked for clarification as to why s/he did not order Resident 5's INR testing until after s/he was treated for a blood clot. NP M stated, "I observe Resident 5 every Tuesday as I am a traveling nurse practitioner. I was not monitoring Resident 5's INR levels because I did not prescribe the Warfarin, I assumed [his/her] prescribing physician was monitoring [his/her] INR levels." NP M stated the provider did not ask him/her to monitor his/her INR levels. NP M explained that after Resident 5 had been treated for a blood clot, s/he had been asked to monitor his/her INR levels. Surveyor asked if Resident 5 required changes to his/her Warfarin dosage since NP M had started requesting INR testing. NP M stated, "I am reviewing the INR every week, and I have had to make adjustments to [his/her] dosages." Resident 5's Medication Administration Records (MARs), dated 04/01/2025 to 07/24/2025, documented: "Warfarin Sodium Oral Tablet 2 MG (milligram) - Give 3 MG by mouth one time a day related to unspecified atrial fibrillation. Start Date: 12/18/2024. Discontinued Date: 06/18/2025." "Warfarin Sodium Oral Tablet 2 MG (milligram) - Give 3 MG by mouth one time a day related to unspecified atrial fibrillation Monday - Friday then 5 MG on Saturday and Sunday. Start Date: 06/19/2025." On 07/24/2025 at 11:13 AM, Surveyor interviewed Administrator A and Nurse B. Surveyor requested clarification as to why Resident 5 did not receive regular INR testing. Nurse B stated that NP M had requested the original INR testing when Resident 5 moved into the facility, as s/he was the traveling nurse practitioner, and we	N 431		

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encourage residents to sign on with him/her due to the convenience. Nurse B stated that when the traveling lab discontinued their services, s/he did not know where residents should obtain these tests. Surveyor asked if Nurse B had discussed these concerns with NP M, as NP M was under the impression that Resident 5's primary physician or his/her cardiologist was ordering the INR testing. Nurse B stated s/he had discussed the concern with NP M but did not have any documentation to show that the conversations had occurred. Surveyor asked if a resident admitted to the facility and was prescribed a blood thinner, would Nurse B expect to see INR testing requests. Nurse B stated, "Yes, and unfortunately, it appears [Resident 5] slipped through the cracks while I determined where residents could obtain their blood work." Nurse B explained that s/he should have followed up with Resident 5's medical team and determined who was responsible for the ordering of his/her INR testing and ensured there was proper documentation. Nurse B stated NP M explained where residents could go to obtain lab work and Nurse B was driving residents to the location if there were transportation concerns. Administrator A stated s/he could forward Resident 5's INR testing documentation since his/her admittance. Surveyor stated additional documentation could be submitted, along with Resident 5's July 2025 MAR, by the end of the day, 07/24/2025.

On 07/25/2025 at 5:42 AM, Surveyor emailed Administrator A and stated s/he had not received any additional documentation, and that the documentation needed to be provided by 11:00 AM, 07/25/2025.

On 07/25/2025 at 1:36 PM, Surveyor received the

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following documentation from Administrator A:
INR lab order request by NP M, dated 11/06/2024, which stated, "Please obtain PT/INR on 11/25/2024."
INR lab order request by NP M, dated 12/10/2024, which stated, "Please obtain PT/INR on 12/20/2024. Warfarin was increased to 3 MG once daily."
INR lab order request by NP M, dated 05/13/2025, which stated, "PT/INR." Surveyor did not receive a lab result.

In summary, based on a review of progress notes and documents provided from Administrator A, Resident 5's INR was not monitored at least monthly from 12/20/2024 until 06/03/2025, when Resident 5 was hospitalized.

"Anticoagulation medications that slow or decrease the body's ability to form dangerous blood clots play a crucial role in both the prevention and treatment of blood clots. Patients prescribed warfarin are required to undergo routine blood tests to make sure the dose is correct. Different factors, such as genetics, weight, diet, other illnesses, and potential interactions with other medications, cause people to respond differently to warfarin therapy. This is why warfarin requires patient-specific dosing and monitoring. Healthcare providers adjust the dosage of warfarin based on the results of routine blood tests all warfarin patients are required to undergo. Patients prescribed warfarin must have their blood monitored frequently - at least once a month and sometimes as frequently as twice weekly - to confirm that the dose of warfarin prescribed is in a safe and effective range."
(Source: National Blood Clot Alliance website, Stop The Clot, undated, https://www.stoptheclot.org/about-clots/blood-clot

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N 431	Continued From page 6 -treatment/warfarin/inr-self-testing/ (retrieval date - July 24, 2025).)	N 431		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all rooms were clean and free from odor. Resident 4's room emanated a urine like scent which was detectable when walking down the hallway. Findings include: On 07/10/2025, at approximately 12:35 PM, Surveyor and Administrator A were walking down a hallway that led to the resident bedrooms and detected a strong urine like scent. Surveyor and Administrator A entered Resident 4's room where the scent appeared to be emanating from. Surveyor pulled back the blanket on Resident 4's made bed and observed 2 chuck pads that emanated a urine like scent. The sheets and chuck pads did not display signs that they were soiled but appeared damp. Administrator A commented that s/he did not believe the sheets had been dried properly. Surveyor walked over to Resident 4's recliner that did not contain a protective cover on the sitting area and determined that the recliner emanated a urine like scent. Administrator A observed the full laundry basket with soiled clothing and requested that a caregiver remove the laundry basket and ensure	N 489		

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N 489	Continued From page 7 the clothing was washed with vinegar, to assist with the urine like scent. Surveyor and Administrator A walked into Resident 4's bathroom where a shower brush hanging in the shower displayed a brown colored substance along the side. Administrator A removed the brush and stated s/he would inform family that the item needed to be replaced. Surveyor and Administrator A detected a strong odor emanating from the shower drain but were unable to determine the source. Administrator A stated s/he would ask housekeeping to do a deep clean in Resident 4's room. Surveyor and Administrator A walked through additional resident rooms and determined an unpleasant scent was emanating from the shower drains. Administrator A stated that the grease traps in the kitchen had recently been cleaned and flushed and wondered if that was the cause of the odor. Administrator A stated s/he would follow up with maintenance.	N 489		