

Wisconsin Department of Health Services

|                                                            |                                                                                                                                                                      |                                                                                           |                                                                                                                          |                                                        |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>410429</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/13/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRINITY TERRACE</b> |                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1835 DIVISION ST<br/>NEW LONDON, WI 54961</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                         | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| N 000                                                      | <p>Initial Comments</p> <p>On 03/13/2025, Surveyor conducted an abbreviated survey at Trinity Terrace. No deficient practices were identified.</p> <p>Census: 26</p> | N 000                                                                                     |                                                                                                                          |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE