STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 000	INITIAL COMMENTS On 02/18/2026 to 02/20/2026, Surveyor conducted a standard survey at Trinity Adult Family Home LLC. Five deficiencies were identified. Census: 3	M 000		
M 314	88.05(3)(i) BATHROOM LOCK The door of each bathroom shall have a lock which can be opened from the outside in an emergency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 bathroom door had a lock. The provider's resident bathroom door was a curtain. Findings include: On 02/18/2026 at 10:02 AM, Surveyor observed the provider's resident bathroom. The door was missing and a white curtain was hung from ring clips. The curtain covered much of the doorway leaving an approximately 1-foot section at the bottom uncovered. On 02/18/2026 at 10:04 AM, Surveyor interviewed Caregiver B. Caregiver B reported s/he had worked at the home for 7 months and the curtain had been there since s/he started. On 02/18/2026 at 10:47 AM, Surveyor interviewed Licensee A. Surveyor shared concern with Licensee A regarding the missing door in the	M 314		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 314	Continued From page 1 resident bathroom. Licensee A reported the home was in the process of installing a pocket door to save space as one of the resident's wheelchair did not fit through the old door. Licensee A stated the curtain was a temporary fix until their maintenance person could make the updates. Surveyor asked Licensee A if s/he had requested a temporary waiver. Licensee A stated "no." Licensee A reported all residents in the home required full assistance with bathing and toileting needs meaning staff were ensuring their privacy. Licensee A stated s/he would work on getting a new door installed with a lock in the near future.	M 314		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 332	Continued From page 2 department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure home's fire extinguishers had an attached tag showing the date of the last dealer or fire department inspection. The provider's 2 of 2 fire extinguishers did not have an attached tag. Findings include: On 02/18/2026, Surveyor toured the provider's home. At 10:13 AM, Surveyor observed a fire extinguisher mounted in the kitchen. The fire extinguisher did not have a tag attached showing the date of the last inspection. At 10:18 AM, Surveyor observed a fire extinguisher mounted in the basement. The fire extinguisher did not have a tag attached showing the date of the last inspection. On 02/18/2026 at 10:47 AM, Surveyor interviewed Licensee A. Surveyor shared concern with Licensee A that the home's fire extinguishers did not have any tags attached indicating the date of the last inspection. Licensee A stated s/he thought s/he had the tags at his/her office. Surveyor noted evidence of the fire extinguisher tags would need to be submitted prior to the exit conference. On 02/20/2026 at 11:08 AM, Surveyor interviewed Licensee A and conducted an exit conference. Surveyor summarized the above concern and Licensee A acknowledged the concern and did not comment about providing the home's fire extinguisher tags.	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 412	Continued From page 3	M 412		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's individual service plan (ISP) included a description of services the licensee would provide to meet assessed need. Resident 3's ISP did not include the use of full-length bed rails. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 412	Continued From page 4	M 412		

the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 02/20/2026)).

Findings include:

On 02/18/2026 at 9:56 AM, Surveyor toured Resident 3's bedroom and observed full length bed rails attached to each side of Resident 3's hospital bed. Additionally, Surveyor observed blue mats secured to the head and foot of the bed.

On 02/18/2026, Surveyor reviewed Resident 3's record. Resident 3 had an unknown admission date to the provider. Resident 3's diagnosis included cerebral palsy, epilepsy, congenital hydrocephalus, and scoliosis of thoracolumbar spine. Resident 3's record indicated s/he was blind, non-verbal, had seizures, and received his/her nutrition/medications via g-tube. Resident 3's ISP dated 01/18/2025 documented: "Resident is total care. [S/he] is unable to ambulate,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 412	Continued From page 5 non-verbal, and blind." The ISP did not address the use of full-length bed rails. On 02/20/2026 at 11:08 AM, Surveyor interviewed Licensee A and conducted an exit conference. Licensee A acknowledged Resident 3 used full length bed rails on his/her hospital bed. Licensee A stated s/he aware of the risk of bed rails and that intervention should have been added to his/her ISP. Licensee A stated s/he would ensure Resident 3's ISP was updated and signed by his/her guardian showing s/he was in agreement to the use of bed rails.	M 412		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents' (Resident 1, Resident 2, and Resident 3) individual service plans (ISPs) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's, Resident 2's, and Resident 3's ISPs did not include a signed statement of agreement with all parties involved. Findings include:	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 420	Continued From page 6 On 02/18/2026, Surveyor reviewed residents' records and identified the following: -Resident 1 was admitted to the provider on 07/31/2023. Resident 1's record indicated s/he had a legal guardian. Resident 1's ISPs dated 08/28/2024, 03/20/2025, and 08/28/2025 were not signed by his/her guardian. -Resident 2 was admitted to the provider on 10/01/2023. Resident 2's record indicated s/he had a legal guardian. Resident 2's ISPs dated 04/20/2025 and 10/20/2025 were not signed by his/her guardian. -Resident 3 had an unknown admission date. Resident 3's record indicated s/he had a legal guardian. Resident 3's ISP dated 07/18/2025 was not signed by his/her guardian. On 02/18/2026 at 10:47 AM, Surveyor interviewed Licensee A. Surveyor shared concern with Licensee A regarding missing legal representative signatures on resident ISPs. Licensee A acknowledged residents' ISPs did not include a signed statement of agreement from all parties. Licensee A stated s/he was behind on paperwork for residents, but s/he will do better in the future to acquire all required signatures.	M 420		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 570	Continued From page 7 home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment with residents safeguarded from environmental hazards from which they were likely to be exposed. The faucet water temperature of the resident bathroom and kitchen sinks exceeded 120 ° Fahrenheit (F). Findings include: The provider is licensed to serve up to 4 adults in the following client groups: emotionally disturbed/mental illness, developmentally disabled, advanced age, and irreversible dementia/Alzheimer's. On 02/18/2026 at 10:07 AM, Surveyor tested the water temperature of the sink in the resident bathroom, which reached 131° F. At 10:16 AM, Surveyor tested the water temperature of the sink in the provider's kitchen, which reached 138° F. Surveyor observed at the kitchen sink faucet there was visible steam. According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019470	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ADULT FAMILY HOME LLC	2813 WIMBLEDON WAY MADISON, WI 53713

(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
M 570	Continued From page 8 environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with water at or above 140° F can result in second or third-degree burns in approximately 6 seconds (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). On 02/18/2026 at 10:47 AM, Surveyor interviewed Licensee A. Surveyor shared concern with Licensee A regarding the hot water temperature observed within the home. Licensee A acknowledged Surveyor's concern and stated s/he would turn down the water heater.	M 570		