STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019496	A. BUILDING: _____ B. WING _____	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOME	10320 S HUMMINGBIRD LN OAK CREEK, WI 53154

(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
N 000	Initial Comments On 07/02/2024, Surveyor concluded a complaint investigation at Trinity Home. As a result, 1 deficient practice was identified. One compliant was substantiated. Census: 6	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 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.	N 431		

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

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N 431	Continued From page 1	N 431		

This Rule is not met as evidenced by:
Based on record review and interviews, the provider did not ensure 1 of 1 resident reviewed (Resident 1) received health monitoring from staff to have blood sugar checks at intervals prescribed by a practitioner. Resident 1's medical record contained physicians orders for blood sugars to be taken two times weekly, fasting. Resident 1 did not have his/her blood sugar checked a total of ten out of twenty-one times between 04/17/2024 and 06/25/2024.

Findings Include:

On 04/11/2024, the Department received a complaint indicating a resident was not receiving blood sugar checks at the intervals prescribed by the practitioner.

On 06/27/2024 at approximately 10:45 a.m., Surveyor reviewed the record for Resident 1. The record indicated Resident 1 was admitted to the facility on 10/28/2021. Additionally, the provider managed and administered all Resident 1's medication and blood sugar testing.

Resident 1's medical record contained physicians orders for, "Blood sugars, two times weekly, fasting." The order indicated to take blood sugars at 8:00 a.m. on Tuesdays and Fridays.

On 06/27/2024 at approximately 11:15 a.m., Surveyor reviewed Resident 1's handwritten

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N 431	Continued From page 2	N 431		

blood sugar log. Surveyor observed a handwritten note on top of the document that read, '3rd shift.' The log started on 04/14/2024 and concluded on 06/22/2024. In April 2024, Resident 1 missed 2 out of 5 prescribed blood sugar checks. In May 2024, Resident 1 missed 3 out of 9 prescribed blood sugar checks. Surveyor noted on May 31st, the blood sugar test was taken, however, it was taken at 1:00 p.m. In June 2024, Resident 1 missed 5 out of 7 prescribed blood sugar checks. Resident 1 did not have his/her blood sugar checked a total of ten out of twenty-one times between 04/17/2024 and 06/25/2024.

On 06/27/2024 at approximately 11:25 a.m., Surveyor reviewed Resident 1's April, May, and June 2024 Medication Administration Record (MAR), and identified the following:

-The 04/05/2024 to 05/02/2024 MAR read, "charted separately."
-The 05/03/2024 to 05/30/2024 MAR read, "charted separately," with signatures on 05/03/2024, 05/07/2024, 5/10/2024, 5/14/2024, 5/17/2024 and 5/21/2024.
-The 05/31/2024 to 06/30/2024 MAR read, "charted separately," with signatures on 06/04/2024 and 06/14/2024.

On 06/27/2024 at approximately 11:35 a.m., Surveyor interviewed Caregiver B, who stated Previous Manager (PM) C told third shift to conduct the blood sugars for Resident 1. Caregiver B stated s/he was not aware third shift staff was not doing the blood sugars. Caregiver B stated she became aware a week or two ago when Resident 1's care manager evaluated the blood sugar log. Surveyor asked Caregiver B what s/he did when s/he found out the blood sugars were not being done. Caregiver B did not

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N 431	Continued From page 3 have an answer. Caregiver B indicated on 05/31/2023, the previous manager (PM) D, took Resident 1's blood sugar after lunch, and was not within prescribed time parameters and it was not a fasting blood sugar. "I don't know why [s/he] did that. S/He was supposed to be a manger and know better." On 06/27/2024 at approximately 11:40 a.m., Surveyor reviewed Resident 1's blood sugar log and MAR for June 2024 with Caregiver B. Caregiver B confirmed s/he started his/her shift at 8:00 a.m. Caregiver confirmed Resident 1's log recorded blood sugar was taken at 7:00 a.m. on 06/04/2024 and at 7:26 a.m. on 06/14/2024. Surveyor confirmed Caregiver B's initials on Resident 1's MARs dated on 06/04/2024 and 06/14/2024. Caregiver B stated, "I made a mistake. I must have just signed it." On 06/27/2024 at approximately 11:45 a.m., Surveyor interviewed Resident 1, who stated, "I can't quite recall the last time I had my blood sugars done. Maybe two or three weeks ago. The third shift caregivers don't like to wake me up to do the blood sugar tests." On 07/02/2024 at approximately 1:35 p.m., Surveyor interviewed and informed Licensee A of the above findings. Licensee A stated PM C was, "dropping the ball. S/He is gone now. We are looking for a new manager." Surveyor asked Licensee A who was monitoring the MARs if there was no manager. Licensee A stated, "It needs to be me reviewing the MARs at that facility. We had four staff leave at one time. Doing the MARs and checking them are on me."	N 431		