DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 8, 2026

Administrator
The Birches at Trillium Woods
14585 59TH AVENUE NORTH
PLYMOUTH, MN 55446

RE: CCN:245627

Cycle Start Date: May 27, 2026

Dear Administrator:

On May 27, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR  488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

**DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Judy Loecken, Regional Operations Supervisor**
**St. Cloud B District Office**
**Health Regulation Division**
**Minnesota Department of Health**
**4140 Thielman Lane**
**Saint Cloud, Minnesota 56301-4557**
**Email: judy.loecken@state.mn.us**
**Office: (320) 223-7300 Mobile: (320) 426-0175**

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance.  In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed.  Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

**FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by August 27, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 27, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated.  This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement.  Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

**INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process.  You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:  https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:  https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 8, 2026

Administrator
The Birches at Trillium Woods
14585 59TH AVENUE NORTH
PLYMOUTH, MN 55446

Re: State Nursing Home Licensing Orders
Event ID: 230F66-H1

Dear Administrator:

The above facility survey was completed on May 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by."  Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION."  THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.  THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text.  You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.  We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

**Judy Loecken, Regional Operations Supervisor**
**St. Cloud B District Office**
**Health Regulation Division**
**Minnesota Department of Health**
**4140 Thielman Lane**
**Saint Cloud, Minnesota 56301-4557**
**Email: judy.loecken@state.mn.us**
**Office: (320) 223-7300 Mobile: (320) 426-0175**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245627 | A. BUILDING **01 - TRILLIUM W...** B. WING | **05/26/2026** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **The Birches at Trillium Woods** | **14585 59TH AVENUE NORTH , PLYMOUTH, Minnesota, 55446** |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| K0000 Bldg. 01 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted on 05/26/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Birches at Trillium Woods was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>Healthcare Fire Inspections<br><br>State Fire Marshal Division<br><br>445 Minnesota St., Suite 145 | K0000 | | 07/10/2026 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245627 | (X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - TRILLIUM W...** B. WING | (X3) DATE SURVEY COMPLETED **05/26/2026** |
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| K0000 Bldg. 01 | Continued from page 1<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br><br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Trillium Woods is a 3-story building with a partial basement built of Type II(111) construction built in 2015. Each floor is divided into 2 smoke compartments by smoke barriers. The basement and first floor are separated from the rest of the campus by a 2 hour fire barrier.<br><br>The facility has a capacity of 44 beds and had a census of 40 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K0000 | | 07/10/2026 |
| K0921 SS = F Bldg. 01 | Electrical Equipment - Testing and Maintenanc<br><br>CFR(s): NFPA 101<br><br>Electrical Equipment - Testing and Maintenance Requirements<br><br>The physical integrity, resistance, leakage current, | K0921 | Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all | 07/10/2026 |

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| K0921 SS = F Bldg. 01 | Continued from page 2<br>and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.<br><br>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility<br><br>Findings include:<br><br>On 5/26/2026 at 1:45 PM, it was revealed by a review of the available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested.<br><br>An interview with the Director of Plant Operations verified these deficient findings at the time of discovery. | K0921 | Continued from page 2<br>deficiencies, statements, findings, facts, and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.<br><br>A general survey summary was brought to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on June 15, 2026. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on July 20, 2026.<br><br>K0921: Electrical Equipment – Testing and Maintenance<br><br>A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>No residents suffered adverse effects. Immediately during inspection, contacted vendor to provide documentation. Vendor supplied documentation and facility provided to fire marshal post visit. Pursuing new vendor that State of MN appears to use.<br><br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>New vendor to complete annual PCREE testing and results bring to QAPI.<br><br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>New vendor to provide hard copies of PCREE testing in conjunction with digital portal. The Plant Ops Director or Designee will audit annually to ensure that compliance is attained.<br><br>Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>The Plant Ops Director or Designee<br><br>The actual or proposed date for completion of the remedy.<br><br>July 10, 2026 | 07/10/2026 |

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| E0000 | Initial Comments<br><br>On 5/26/26 through 5/27/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E0000 | | 06/16/2026 |
| F0000 | INITIAL COMMENTS<br><br>On 5/26/26 through 5/27/26, Risk Based Survey (RBS) recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F0000 | | 07/26/2026 |
| F0572<br>SS = F | Notice of Rights and Rules<br><br>CFR(s): 483.10(g)(1)(16)<br><br>§483.10(g) Information and Communication.<br><br>§483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and | F0572 | F572: Notice of Rights and Rules<br><br>How the nursing facility will correct the deficiency as it relates to the residents:<br><br>No residents suffered adverse effects from this practice. Immediately facility acquired and posted most up to date resident rights on each floor for | 06/22/2026 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0572<br>SS = F | Continued from page 1<br>regulations governing resident conduct and responsibilities during his or her stay in the facility.<br><br>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.<br><br>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.<br><br>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.<br><br>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 40 residents currently residing in the facility as well as all staff and visitors.<br><br>Findings include: On 5/27/26 at 7:27 a.m. displayed next to double doors to enter first floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:52 a.m. displayed next to double doors to enter second floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:56 a.m. displayed next to double doors to enter third floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 8:26 a.m. administrator stated they were not aware there were changes to the RBOR. At 9:21 a.m. administrator returned, stated they have now started the process of providing updates to the residents and resident representatives. They have not yet ordered new postings for the units. Facility Resident Resident Rights policy dated 10/24, indicated copies of the resident rights was posted throughout the facility, however, the policy did not indicate when the facility would provide notification of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility. | F0572 | Continued from page 1<br>residents, visitors, and staff to review. Most up to date resident rights immediately provided to each resident.<br><br>How the nursing facility will identify other residents having the potential to be affected by the same practice:<br><br>All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected. Immediate review of all residents to ensure each resident has a copy of the updated resident rights.<br><br>Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur:<br><br>Audit monthly to ensure accurate information is posted and all new residents have signed they have acknowledged receipt of the resident rights.<br><br>How does the nursing home plan monitor its performance to make sure that solutions are sustained?<br><br>The Administrator or Designee will audit monthly for two months. Results will be brought to QAPI for two months or until sustained compliance occurs.<br><br>Date it will be corrected: June 22, 2026<br><br>Title of the person responsible for ensuring correction: Administrator or Designee | 06/22/2026 |
| F0628<br>SS = D | Discharge Process<br><br>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) | F0628 | F0628: Discharge Process<br><br>How the nursing facility will correct the deficiency as it relates to the residents: | 07/26/2026 |

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| F0628 SS = D | Continued from page 2<br>§483.15(c)(2) Documentation.<br><br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br><br>(iii) Information provided to the receiving provider must include a minimum of the following:<br><br>(A) Contact information of the practitioner responsible for the care of the resident.<br><br>(B) Resident representative information including contact information<br><br>(C) Advance Directive information<br><br>(D) All special instructions or precautions for ongoing care, as appropriate.<br><br>(E) Comprehensive care plan goals;<br><br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br><br>§483.15(c)(3) Notice before transfer.<br><br>Before a facility transfers or discharges a resident, the facility must-<br><br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br><br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br><br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br><br>(i) Except as specified in paragraphs (c)(4)(ii) and | F0628 | Continued from page 2<br><br>No residents suffered adverse effects from this practice. Immediately following the information, resident R7 was assessed. Education was initiated with nurses immediately related to how to ensure residents are informed on the bed hold before any transfers<br><br>How the nursing facility will identify other residents having the potential to be affected by the same practice:<br><br>All residents who get transferred out have the potential to be affected by this practice. No residents have been noted to be adversely affected. Immediately a review of all residents was completed. All current residents who were hospitalized or went to ER visit had signed a bed hold before transfer.<br><br>Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur:<br><br>IDT, Nurses and medical records additional training implementing for bed hold.<br><br>How does the nursing home plan monitor its performance to make sure that solutions are sustained?<br><br>The Director of Nursing or Designee will audit monthly for two months. Results will be brought to QAPI for two months or until sustained compliance occurs.<br><br>Date it will be corrected:<br><br>July 26, 2026<br><br>Title of the person responsible for ensuring correction: Director of Nursing or Designee | 07/26/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245627 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/27/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **The Birches at Trillium Woods** | **14585 59TH AVENUE NORTH , PLYMOUTH, Minnesota, 55446** |

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| F0628 SS = D | Continued from page 3<br>(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br><br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br><br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br><br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br><br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br><br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br><br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br><br>(i) The reason for transfer or discharge;<br><br>(ii) The effective date of transfer or discharge;<br><br>(iii) The location to which the resident is transferred or discharged;<br><br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental | F0628 | | 07/26/2026 |

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| F0628 SS = D | Continued from page 4<br>disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br><br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br><br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br><br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br><br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br><br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1 ) of this section, permitting a resident to return; and | F0628 | | 07/26/2026 |

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| F0628 SS = D | Continued from page 5<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br><br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br><br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on document review and interview, the facility failed to ensure all residents were offered written notice for bed hold for 1 of 3 residents (R7) who were reviewed for discharges / transfers from the facility.<br><br>Findings include - In review of R7's Admission Record (print date 5/27/26), documented were the following diagnoses: effusion right elbow (a buildup of excess fluid within the elbow joint capsule), peripheral vascular disease, and end stage real disease with dependence on dialysis. A review of R7's most recent quarterly Minimum Data Set (MDS) dated 4/29/26, documented R7 was cognitively intact and required substantial - maximal assistance with activities of daily living. In review of R7's electronic medical records (EMR), Resident's progress notes documented the facility received a phone call at 12:00 p.m., from R7's dialysis unit, reporting resident should be seen in the emergency room (ER) due to experiencing pain in her right arm. | F0628 | | 07/26/2026 |

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| F0628 SS = D | Continued from page 6<br>R7's primary clinic was updated and orders received to send resident to the ER upon her return to the facility. After returning to the facility at 2:10 p.m., the facility sent R7 to the ER for further evaluation. The facility received a call later that evening from Methodist Hospital, informing the facility R7 had been admitted for further testing and MRI (Magnetic Resonance Imaging is a non-invasive medical test that uses powerful magnets and radio waves to create detailed, cross-sectional images of your body's organs, tissues, and skeletal system). Resident returned to the facility on 5/9/26, 3 days later. During an interview on 05/26/2026 at 2:05 p.m., R7 stated she had gone to the hospital earlier in the month but could not remember if she had been offered or signed a bed hold for the transfer. In further review of R7's EMR, there was no evidence the facility had offered resident a bed hold in writing. During interview on 5/27/26 at 10:21 a.m., the facilities licensed social worker (LSW) stated, when residents are transferred to the hospital, the resident, family / significant other are offered a bed hold, which is reviewed with them and is signed if a bed hold is requested. LSW stated until the forms are scanned into the EMR, they are located in the resident's paper hard chart at the nurses station. A review of R7's hard paper chart lacked evidence R7 and / or her family were offered a bed hold in writing. In a interview on 5/27/26 at 2:10 p.m., the director of nursing (DON) stated the staff might not have offered a bed hold while "it is the courtesy of the corporation to hold a bed when someone goes to the hospital". During an interview on 5/27/26 at 3:43 p.m., both the DON and the administrator (ADM) stated they were unable to locate a signed / written bed hold for the 5/6/26 hospitalization of R7. Both the DON and ADM stated it would be the facility's expectation a bed hold be offered either to the resident and/or their family. In review of the facility's Admission Packet (undated), the following was documented: "Section 6. BED HOLD POLICY, if you are absent from the Health Center, we shall hold your bed in accordance with our current bed hold policy. A copy of the current bed hold policy is included in these documents listed in the attached Checklist, We reserve the right to change our bed hold policy from time to time in accordance with applicable laws and regulations. A copy of the current bed hold policy shall be provided to you and your family member or legal Representative, Responsible party, or Resident Representative before your transfer." In review of the facility's Policy and Procedure form, entitled: Trillium Woods Policy and Procedure - Bed Hold / Leave of Absence Policy and Acknowledgement (undated), documented three types of resident stays, each with different | F0628 | | 07/26/2026 |

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| F0628 SS = D | Continued from page 7<br>requirements and time lines for bed hold: Medicare or Private Pay Resident, Medicaid Resident and Life Care Resident on the same form. However, for each resident stay type, the document read, "Resident (and/or Resident's legal Representative, if applicable) hereby acknowledge(s) receipt of the Health Center Bed Hold Policy", with a line for a signature and date signed. | F0628 | | 07/26/2026 |
| F0697 SS = D | Pain Management<br><br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br><br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review the facility failed to ensure provider orders were followed which caused pain for 1 of 1 residents (R58) reviewed.<br><br>Findings include:<br><br>R58's admission Minimum Data Set (MDS) dated 4/21/26, indicated R58 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs). R58's diagnoses included presence of artificial hip joint, anxiety, pain, femur fracture, and Alzheimers disease<br><br>R58's care plan revised 5/6/26, indicated R58 was on pain medication therapy related to hip surgery, the care plan included an intervention to administer medications as ordered.<br><br>During interview on 5/26/26, at 3:37 p.m. family member (FM)-A stated they had asked for lidocaine to be applied to R58's skin before she was given her injection to help decrease the pain it caused her. FM-A stated the nurses were not consistently doing the lidocaine before the injection, some were doing it after, some were not doing it at all, some would put it on one area then do the injection somewhere else. | F0697 | F 628 Discharge Process - should be completion date of June 26, 2026 – discussed with MDH Supervisor<br><br>F0697: Pain management<br><br>How the nursing facility will correct the deficiency as it relates to the resident:<br><br>Immediately following the information, Resident R58 assessment was reviewed for pain.<br><br>Immediate education done with involved team members. All staff education initiated to nurses immediately related to pain management.<br><br>How the nursing facility will identify other residents having the potential to be affected by the same practice:<br><br>All residents with evident pain management program have the potential to be affected by this practice. No other residents have been noted to be adversely affected. Immediately review of all residents with possible pain was completed. No further action was needed.<br><br>Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur:<br><br>Nurses additional training being completed for Pain management. Track any changes with new admits to ensure procedures in place for each related to pain management.<br><br>How does the nursing home plan monitor its performance to make sure that solutions are sustained?<br><br>The Director of Nursing or Designee will audit weekly for one month and then monthly for one month. Results will be brought to QAPI for two months or until sustained compliance occurs.<br><br>Date it will be corrected: | 06/26/2026 |

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| F0697 SS = D | Continued from page 8<br>On 5/26/26, at 3:51 p.m. licensed practical nurse (LPN)-A entered R58's room to administer R58's injection, FM-A asked LPN-A if the lidocaine was going to be applied before the injection was given so she has less pain, LPN-A stated to FM-A "no, we put it on after to take away the pain" FM-A stated no, the lidocaine was supposed to be put on at least fifteen minutes before so she doesn't feel the injection, LPN-A repeated the lidocaine was put on after. LPN-A proceeded to give the injection, R58 screamed out "ouch, ouch don't do that you jerk' while striking out at the nurse.<br><br>R58's electronic medical record (EMR) was reviewed, the EMR indicated R58 had orders for:<br><br>Lidocaine external gel 4% (local anesthetic applied to the skin to temporarily numb the area) apply thin layer to the area enoxaparin injection thirty minutes prior to injection once daily.<br><br>Enoxaparin sodium injection solution prefilled syringe 40millegram(mg)/0.4milliliters (ml) (prescription blood thinner) inject 0.4ml subcutaneously (subq) one time daily.<br><br>On 5/27/26, at 9:54 a.m. registered nurse (RN) – A removed an enoxaparin sodium injection solution prefilled syringe from R58's medication cabinet, RN-A administered the injection into R58's abdomen, R58 screamed out "ouch, damn it you jerk, that hurt" resident continued yelling at RN-A, grabbed RN-As arm then scratched the back of RN-A's hand. Staff offered R58 breakfast, R58 stated "I don't want breakfast damn it."<br><br>When interviewed on 5/27/26, at 10:22 a.m. RN-A stated they would reapproach R58 to apply the lidocaine gel to the injection site after R58 had time to calm down from getting upset after the injection. RN-A stated it would not be a good idea to try it now due to R58 was too upset and would not allow her to apply the gel. RN-A reviewed R58's EMR then stated "oh I should have applied that before the injection was done, I did not do it."<br><br>When interviewed on 5/27/26, at 2:19 p.m. director of nursing (DON) stated the expectation was for nurses to review the residents' orders prior to administering medications to ensure they were correctly administering the medications as they were ordered by the provider. DON stated applying the | F0697 | Continued from page 8<br>June 26, 2026<br><br>Title of the person responsible for ensuring correction: Director of Nursing or Designee | 06/26/2026 |

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| F0697 SS = D | Continued from page 9<br>lidocaine after the injection would not help R58 with the pain from administration.<br><br>Facility policy Pain Assessment and Management dated 2001. indicated staff to observe from behavioral signs of pain which included negative verbalizations and vocalizations such as groaning, crying and screaming; be3havior such as resisting care, irritability decreased participation in usual physical/social activities. | F0697 | | 06/26/2026 |
| F0759 SS = D | Free of Medication Error Rts 5 Prcnt or More<br><br>CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure residents were free of medication errors of less than 5% for 1 of 2 residents (R58) observed for medication administration resulting in a 7.69% error rate.<br><br>Findings include:<br><br>R58's electronic medical record (EMR) was reviewed, the EMR indicated R58 had orders for:<br><br>Lidocaine external gel 4% (local anesthetic applied to the skin to temporarily numb the area) apply thin layer to the area enoxaparin injection thirty minutes prior to injection once daily.<br><br>Enoxaparin sodium injection solution prefilled syringe 40millegram(mg)/0.4milliliters (ml) (prescription blood thinner) inject 0.4ml subcutaneously (subq) one time daily administer lidocaine prior to injection.<br><br>R58 was observed on 5/27/26, at 9:54 a.m. during a medication pass. Registered nurse (RN) – A removed an enoxaparin sodium injection solution prefilled syringe from R58's medication cabinet, RN-A administered the injection into R58's abdomen. | F0759 | F0759: Free of medication errors<br><br>How the nursing facility will correct the deficiency as it relates to the residents:<br><br>Immediately following the information, Resident R58 pain orders and resident was re-assessed. Education was initiated to nurses and TMAs immediately related to how to ensure that the plan of care and pain management is followed.<br><br>How the nursing facility will identify other residents having the potential to be affected by the same practice:<br><br>All residents have the potential to be affected by this practice. No other residents have been noted to be adversely affected. Immediate review of all residents was completed and their pain plans are being followed.<br><br>Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur:<br><br>Nurses and TMA training implemented for following orders as prescribed.<br><br>How does the nursing home plan monitor its performance to make sure that solutions are sustained?<br><br>The Director of Nursing or Designee will audit monthly for two months. Results will be brought to QAPI for two months or until sustained compliance occurs.<br><br>Date it will be corrected:<br><br>June 26, 2026<br><br>Title of the person responsible for ensuring correction: Director of Nursing or Designee | 06/26/2026 |

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| F0759 SS = D | Continued from page 10<br><br>On 5/27/26, at 10:22 a.m. RN-A stated she would approach R58 in about five minutes and apply the lidocaine gel. RN-A reviewed R58's EMR and stated, "oh I should have applied that before the injection was done, I did not do it."<br><br>When interviewed on 5/27/26, at 2:19 p.m. director of nursing (DON) stated the expectation was for nurses to review the residents' orders prior to administering medications to ensure they were correctly administering the medications as they were ordered by the provider.<br><br>Facility Administering Medications policy stated 4/19, indicated medications were administered in accordance with prescriber orders, this included any required time frame. | F0759 | | 06/26/2026 |

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br><br>On 5/26/26 through 5/27/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the | 20000 | | 06/26/2026 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**05/27/2026** |
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| 20000 | Continued from page 1<br>State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 20000 | | 06/26/2026 |
| 21426 | Tuberculosis Prevention And Control<br><br>CFR(s): MN St. Statute 144A.04 Subd. 3<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis<br><br>infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid | 21426 | Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.<br><br>A general survey summary was brought to The Birches at Trillium Woods Quality Assurance | 06/15/2026 |

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| 21426 | Continued from page 2<br>employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to ensure a two-step tuberculin skin test (TST) was completed for 2 of 6 employees (nursing assistant (NA)-A and dietary aid (DA)-A) reviewed for tuberculosis (TB) testing.<br><br>Findings include: DA-A's hire date was 2/17/26. DA-A's employee record indicated DA-A had received a step-one TET on 2/19/26, however, DA-A's employee record failed to indicate a step-two TST was completed. NA-A's hire date was 3/25/26. NA-A's employee record indicated NA-A received a step-one TST on 3/25/26, however, NA-A's employee record failed to indicate a step-two TST was completed. During interview on 5/27/26 at 2:16 p.m. director of nursing (DON) stated human resources (HR) ensured the TB screening was completed hen sent that over and one of the nurses administered the TST, DON stated was not sure why the second TST had not been completed for the two staff members. Facility Tuberculosis, employee screening for policy dated 3/2021, indicated employees are screened for latent TB infection and active TB disease, using TST and symptom screening prior to beginning employment. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could review/update the facility's policy and procedures and educate the facility staff responsible for the provision of TB skin testing and symptom screening.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | Continued from page 2<br>Performance Improvement Committee on June 15, 2026. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on July 20, 2026.<br><br>21426: Tuberculosis Prevention and Control<br><br>How the nursing facility will correct the deficiency as it relates to the residents:<br><br>No residents or staff suffered adverse effects from this practice<br><br>(NA)-A and (DA)-A were scheduled promptly for the TB Gold test. The test was completed, yielded a negative result, and was submitted to MDH.<br><br>How the nursing facility will identify other residents having the potential to be affected by the same practice:<br><br>All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected. An audit of all employee health files was conducted to identify any staff who began work without completed TB screening. Staff schedules were reviewed to determine if any residents may have been exposed to non-compliant staff.<br><br>Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur:<br><br>All new hires will be required to complete a TB Gold (IGRA) blood test upon hire as part of the pre-employment/employee health screening process.<br><br>Employees will not be permitted to work in resident care areas until a negative TB result is received and documented, consistent with infection control expectations.<br><br>How does the nursing home plan monitor its performance to make sure that solutions are sustained?<br><br>The HR Director or designee will verify completion of TB tests prior to employees working with residents and conduct weekly audits for compliance. Any | 06/15/2026 |

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| 21426 | | 21426 | Continued from page 3<br>variances will be addressed through corrective action and monitored through the facility's QAPI program for a period of 3 months or until sustained compliance occurs.<br><br>Date it will be corrected: June 15th, 2026<br><br>Title of the person responsible for ensuring correction: Director of Human Resources or Designee | 06/15/2026 |
| 21545 | Medication Errors<br><br>CFR(s): MN Rule 4658.1320 A.B.C<br><br>A nursing home must ensure that:<br><br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:<br><br>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or<br><br>(2) the administration of expired medications.<br><br>B. It is free of any significant medication error. A significant medication error is:<br><br>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or<br><br>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>C. All medications are administered as prescribed. | 21545 | corrected | 06/26/2026 |

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| 21545 | Continued from page 4<br>An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure residents were free of medication errors of less than 5% for 1 of 2 residents (R58) observed for medication administration resulting in a 7.69% error rate.<br><br>Findings include:<br><br>R58's electronic medical record (EMR) was reviewed, the EMR indicated R58 had orders for:<br><br>Lidocaine external gel 4% (local anesthetic applied to the skin to temporarily numb the area) apply thin layer to the area enoxaparin injection thirty minutes prior to injection once daily.<br><br>Enoxaparin sodium injection solution prefilled syringe 40millegram(mg)/0.4milliliters (ml) (prescription blood thinner) inject 0.4ml subcutaneously (subq) one time daily administer lidocaine prior to injection.<br><br>R58 was observed on 5/27/26, at 9:54 a.m. during a medication pass. Registered nurse (RN) – A removed an enoxaparin sodium injection solution prefilled syringe from R58's medication cabinet, RN-A administered the injection into R58's abdomen.<br><br>On 5/27/26, at 10:22 a.m. RN-A stated she would approach R58 in about five minutes and apply the lidocaine gel. RN-A reviewed R58's EMR and stated, "oh I should have applied that before the injection was done, I did not do it."<br><br>When interviewed on 5/27/26, at 2:19 p.m. director of nursing (DON) stated the expectation was for nurses to review the residents' orders prior to administering medications to ensure they were correctly administering the medications as they were ordered by the provider. | 21545 | | 06/26/2026 |

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| 21545 | Continued from page 5<br><br>Facility Administering Medications policy stated 4/19, indicated medications were administered in accordance with prescriber orders, this included any required time frame.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure updated and complete; then educate direct care staff and audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days | 21545 | | 06/26/2026 |
| 21800 | Patients & Residents of HC Fac.Bill of Rights<br><br>CFR(s): MN St. Statute144.651 Subd. 4<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 40 residents currently residing | 21800 | corrected | 06/22/2026 |

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| 21800 | Continued from page 6<br>in the facility as well as all staff and visitors.<br><br>Findings include: On 5/27/26 at 7:27 a.m. displayed next to double doors to enter first floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:52 a.m. displayed next to double doors to enter second floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:56 a.m. displayed next to double doors to enter third floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 8:26 a.m. administrator stated they were not aware there were changes to the RBOR. At 9:21 a.m. administrator returned, stated they have now started the process of providing updates to the residents and resident representatives. They have not yet ordered new postings for the units. Facility Resident Resident Rights policy dated 10/24, indicated copies of the resident rights was posted throughout the facility, however, the policy did not indicate when the facility would provide notification of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its policy's and procedures for notification of resident rights upon changes to the Resident Bill of Rights. The administrator or designee could then contact the State Agency to ensure the facility has the most updated version of the Resident Bill of Rights. The facility could develop an auditing system that monitors for ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21800 | | 06/22/2026 |