



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 24, 2025

Licensee

Trillium At Woodsedge

930 Anne Street Northwest

Bemidji, MN 56601

RE: Project Number(s) SL26844016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

Trillium At Woodsedge

July 24, 2025

Page 3

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 000	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL26844016-0</p> <p>On May 19, 2025, through May 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 26 residents; 26 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 650 SS=E	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of</p>	0 650		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 650	<p>Continued From page 1</p> <p>each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <ul style="list-style-type: none"> (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 650	<p>Continued From page 2</p> <p>situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>CNS-B had a hire date of August 24, 1988, and began providing services to residents after August 1, 2021.</p> <p>ULP-D had a hire date of May 23, 2023, to provide direct care services to the licensee's residents.</p> <p>CNS-B and ULP-D's employee records lacked documentation of annual performance reviews that identify areas of improvement needed and training needs.</p> <p>On May 21, 2023, at 11:47 a.m., licensed assisted living director (LALD)-A stated the performance reviews were not completed for CNS-B and ULP-D. Additionally, LALD-A stated she was aware staff performance reviews needed to be completed and had a plan on completing the reviews.</p> <p>The licensee's Performance Management-Enterprise policy dated June 11, 2024, indicated leaders should schedule one-on-one meetings with each of their employees to check-in, provide timely meaningful feedback, discuss performance, share performance ratings, and focus on career growth and development consistently through out the year. Once per year, depending on role requirements, employees and leaders will have the opportunity to seek feedback from others they work with (this is often referred to as a peer review, 360 feedback, etc.)</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 650	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On a facility tour on May 20, 2025, from 10:00 a.m. to 11:30 a.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-E, and maintenance (M)-F, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511:</p> <p>CARBON MONOXIDE ALARMS/ DETECTION</p>	0 775		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 775	<p>Continued From page 4</p> <p>There was a single station carbon monoxide alarm installed in the mechanical/ fire sprinkler riser room that was not tied into the building fire alarm system for notification. The carbon monoxide alarm sounded locally at the location of the activated alarm only.</p> <p>There was not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility.</p> <p>Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide.</p> <p>Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511.</p> <p>STORAGE IN EXIT PATHS</p> <p>Furniture and equipment were observed in the required marked exit path of the link leading to the Neilson Place portion of the building.</p> <p>The required marked exit paths shall be kept free of obstructions that prevent full and immediate use of the required exit path. The required exit paths shall only be used for the purpose of exiting in the event of a fire or similar emergency.</p> <p>During the facility tour LALD-A, DM-E, and M-F, verified the above listed observations while accompanying on the tour.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 775		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
--------------------	--	---------------	---	--------------------

0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire</p>	0 810		
---------------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 810	<p>Continued From page 6</p> <p>safety and evacuation plan with required content, and provide required resident training. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 20, 2025, at 9:15 a.m., licensed assisted living director (LALD)-A, director of maintenance (DM)-E, and maintenance (M)-F, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN</p> <p>The licensee provided FSEP, failed to include the following:</p> <p>The available FSEP included standard resident evacuation procedures for all residents, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency.</p> <p>The individual resident unique needs for</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
0 810	<p>Continued From page 7</p> <p>evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency.</p> <p>During an interview on May 20, 2025, at 9:35 a.m., LALD-A, stated evacuation status unique needs for evacuation for each individual resident were not available in writing for immediate use in the event of a fire or similar emergency.</p> <p>TRAINING</p> <p>Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required resident training was provided annually.</p> <p>During an interview on May 20, 2025, at 9:45 a.m., LALD-A, stated documentation was not available indicating residents were provided training annually as required. LALD-A, also stated their understanding was the residents did not require the training because it is a dementia care facility.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
01500 SS=D	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01500	<p>Continued From page 8</p> <p>vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01500	<p>Continued From page 9</p> <p>incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct care services completed the required annual training for one of two employees, (unlicensed personnel (ULP)-D).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During the entrance conference on May 19, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record.</p> <p>ULP-D was hired on April 23, 2023, and began to provide direct care services to the licensee's residents.</p> <p>On May 20, 2025 at 8:45 a.m., the surveyor</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01500	<p>Continued From page 10</p> <p>observed ULP-D administer R1's morning medications, perform catheter cares, and assist with compression stockings, dressing and grooming.</p> <p>ULP-D's employee record indicated ULP-D received 2024 annual training via online education courses to include: -handling aggressive behaviors; -workplace safety; and -COVID-19 vaccine education.</p> <p>ULP-D's training record lacked the following required annual training: (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01500	<p>Continued From page 11</p> <p>disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>On May 21, 2025, at 11:51 a.m., LALD-A verified ULP-D's training record lacked the above required content. LALD-A stated human resources (HR) assigned the on-line courses and did not assign the correct courses. LALD-A stated annual training is done annually, from January 1 through December 31 every year.</p> <p>The licensee's Required Training for All Employees, Minnesota Assisted Living policy</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01500	<p>Continued From page 12</p> <p>dated July 8, 2024, indicated required annual training requirements:</p> <ul style="list-style-type: none"> -All employees must complete two hours of training on topics related to dementia care including effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -All employees who perform direct care services must complete at least eight hours of annual training. The annual training must include: <ul style="list-style-type: none"> -reporting of maltreatments of vulnerable adults; -review if the assisted bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques, including handwashing techniques, need and use of protective gloves, gowns and masks, appropriate disposal of contaminated materials and equipment, disinfecting reusable equipment, reporting of communicable diseases; -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -training on providing services to clients with hearing loss. <p>The assisted living facility shall retain evidence in the employee record of each staff person having completed the orientation and training required in 144G.63.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01620 SS=E	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01620	<p>Continued From page 14</p> <p>was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1's diagnosis included dementia, paroxysmal atrial fibrillation (irregular heartbeat), and hypertension (high blood pressure).</p> <p>R1's Service Plan dated September 19, 2024, indicated R1 received assistance with medications, behavior management, dressing, compression stockings, catheter cares, toileting, showering, laundry, and housekeeping.</p> <p>R1's record indicated the RN completed a 90-Day Uniform Assessment Review dated January 7, 2025, and May 1, 2025, which exceeded the 90 days from the last assessment (114 days).</p> <p>R2 R2's diagnosis included dementia, hyperlipidemia (high cholesterol) and small cell B-cell lymphoma (type of cancer).</p> <p>R2's Service Plan dated September 19, 2024, indicated R2 received assistance with medications, behavior management, dressing, toileting, showering, laundry, and housekeeping.</p> <p>R2's record indicated the RN completed a 90-Day Uniform Assessment Review dated December 26, 2024, and April 3, 2025, which exceeded the 90 days from the last assessment (98 days).</p> <p>On May 21, 2025, at 11:55 a.m., clinical nurse</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01620	<p>Continued From page 15</p> <p>supervisor (CNS)-B stated she was late in completing the 90-day assessments due to many admissions.</p> <p>The licensee's Resident Medical Record Documentation Requirements-Minnesota dated August 21, 2024, indicated residents must be reassessed or reviewed by an RN on an as needed basis on changes in the residents needs and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01880 SS=F	<p>144G.71 Subd. 19 Storage of medications</p> <p>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperature by failing to monitor and document refrigerator temperatures.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01880	<p>Continued From page 16</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on May 19, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.</p> <p>On May 19, 2025, at 12:05 p.m., the surveyor and CNS-B observed the medication refrigerator and temperature logs located in the locked "hub" (nursing office) in secured unit. The refrigerator had a temperature display on the face of the refrigerator, indicating the temperature was 4.6 Celsius (40.28 Fahrenheit (F)). CNS-B stated staff were expected to monitor and document temperature nightly. CNS-B verified the temperature log lacked consistent temperature monitoring and verified the following medication was stored: -unopened bottle of latanoprost 0.005%.</p> <p>The refrigerator temperature logs from March 1, 2025, through May 19, 2025, indicated the following: -March 2025, eight temperatures were not documented; -April 2025, ten temperatures were not documented; and -May 2025, four temperatures were not documented.</p> <p>The manufacturer's instructions for latanoprost dated September 2020, indicated to store unopened latanoprost in the refrigerator at 36 degrees F to 46 degrees F.</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01880	Continued From page 17 The licensee's Medication Administration and Supporting Process policy dated March 6, 2025, indicated medications are stored at dispensing pharmacists/manufacture instructions for temperature, light and humidity. The temperature of the medication refrigerator will be monitored daily. Temperature requirement is 36-46 degrees F. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration, or indication why the treatment was not administered for one of one resident (R1). This practice resulted in a level two violation (a	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01960	<p>Continued From page 18</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's diagnosis included dementia, paroxysmal atrial fibrillation (irregular heartbeat), and hypertension (high blood pressure).</p> <p>R1's Service Plan dated September 19, 2024, indicated R1 received assistance with compression socks, and catheter cares and bag emptying at least daily.</p> <p>R1's prescriber orders dated March 24, 2025, indicated foley catheter cares-to be done daily and as needed after an incontinent bowel movement. Use all 5 wipes each time following directions on the SureStep package (post insertion foley care wipes for routine hygiene of foley catheter) as needed for foley catheter cares.</p> <p>R1's prescriber orders dated April 21, 2025, indicated thigh high compression socks one time a day for edema in lower extremities (LE), apply in the a.m., and remove in the p.m., wash and hang to dry and remove per schedule.</p> <p>On May 20, 2025, at 8:45 a.m., the surveyor observed ULP-D administer R1's medications, perform catheter cares, and assist with compression socks.</p> <p>R1's May 2025 electronic treatment</p>	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TRILLIUM AT WOODSEdge	STREET ADDRESS, CITY, STATE, ZIP CODE 930 ANNE STREET NW BEMIDJI, MN 56601
--	--

(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
01960	<p>Continued From page 19</p> <p>administration record (ETAR) lacked the following documentation for treatments: -thigh high compression socks-One time a day for edema in LE's, apply in a.m., and remove in p.m., hand wash and hang to dry and remove per schedule: lacked documentation on May 2, 3, 5, 9, 14, 16, 17, 18, 19; and -Foley catheter cares-to be done twice daily and as needed after an incontinent bowel movement, use all 5 wipes each time following the directions on the SureStep package. Two times a day for indwelling foley catheter use SureStep catheter care wipes, on the package each time-follow direction on package: lacked documentation on May 2, 3, 5, 9, 14, 16, 17, 18, 19.</p> <p>On May 21, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-B verified the missing documentation on the ETAR. CNS-B stated she would investigate which staff made these documentation errors.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01960		



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Trillium at Woodsedge
930 Anne Street NW
Bemidji, MN 56601
Beltrami County
Parcel:

Phone:

License Info

License: HFID 26844

Risk:
License:
Expires on:
CFPM: Ed Harapat
CFPM #: 8009; Exp: 10/8/2025

Inspection Info

Report Number: F3822251010
Inspection Type: Full - Single
Date: 5/19/2025 Time: 11:19:03 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

SERVING KITCHEN FROM WINDSONG (INSPECTED FOR HRD 12/10/24). TEMP LOG IN COMPLIANCE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F3822251010 from 5/19/2025

Ed Harapat
Head Cook

Dave Kaufman,
Public Health Sanitarian 3
218-308-2113
david.kaufman@state.mn.us



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

Trillium at Woodsedge
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822251010
Inspection Type: Full
Date: 5/19/2025
Time: 11:19:03 AM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Trillium at Woodsedge
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822251010
Inspection Type: Full
Date: 5/19/2025
Time: 11:19:03 AM

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Wiping Cloth Bucket

Location: Equal To 700 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 160 Degrees F.

Comment:

Violation Issued?: No