DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 17, 2025

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

RE: CCN: 245627
Cycle Start Date: July 31, 2025

Dear Administrator:

On October 28, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 27, 2025

Administrator
The Birches at Trillium Woods

14585 59TH AVENUE NORTH
PLYMOUTH, MN 55446

RE: CCN:245627
Cycle Start Date: July 31, 2025

Dear Administrator:

On July 31, 2025, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 October 31, 2025 (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 January 31, 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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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 07/31/2025

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
E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness requirements was conducted on 7/28/25 through 7/31/25, during a recertificiation survey. The facility was in compliance with the Appendix Z Emergency Preparedness requirements.	E0000		08/28/2025
F0000	INITIAL COMMENTS On 7/28/25 through 7/31/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56271066C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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. 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		08/28/2025
F0574 SS = C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal	F0574	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. A general survey summary was brought to The Birches at Trillium Woods Quality Assurance Performance	09/28/2025

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 B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0574 SS = C	Continued from page 1 funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with	F0574	Continued from page 1 Improvement Committee on August 11, 2025. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on September 15, 2025. F574: Required notices and contact information How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Office of Long-Term Care Ombudsman program was posted in facility prior to survey entry and information book contained specific ombudsman's contact information within each resident's room prior to survey entry. Immediately following the information from survey team, the ombudsman provided his contacts and photo postcard and is posted on each floor. How the nursing facility will identify other residents having the potential to be affected by the same practice: All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Audit monthly and with ombudsman change to ensure accurate information is posted. How does the nursing home plan monitor its performance to make sure that solutions are sustained? The Administrator or Designee will audit monthly for two months. Results will be brought to QAPI for two months or until sustained compliance occurs. Date it will be corrected: Sep 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee/Administrator	

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F0574 SS = C	Continued from page 2 the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide information to 5 of 9 residents (R19, R35, R37, R38, and R42) who attended the resident council group meeting regarding the Ombudsman services as advocates for residents residing in the facility. This had the potential to affect all 42 residents residing in the facility. Findings include: During the resident group meeting held on 7/29/25 at 10:30 a.m., state surveyor, ombudsman, activities coordinator, and R6, R12, R19, R25, R33, R35, R37, R38, and R42 were in attendance. During the meeting R19 had asked the activities coordinator who was the ombudsman for the facility. The activities coordinator response was she did not remember the name of the person but would provide contact information for R19 after the meeting. Further interview on 7/29/25/25 at 11:25 a.m., with state surveyor, ombudsman, and R6, R12, R19, R25, R33, R35, R37, R38, and R42 identified R19, R35, R37, R38, and R42 acknowledged they was not aware of the name of the ombudsman and where to find the information at the facility. Observation on 7/29/25 at 11:25 a.m., with the ombudsman identified the facility first floor, second floor, and third floor had a bulletin posted near the elevators with a Notice of Right to File Complaints and List of Organizational Resources included a section that was identified to be the Office Of Ombudsman For Long Term Care that had an intake number and an email posted. However, the current ombudsman's name and contact information was not posted on the bulletin. Interview on 7/29/2025 at 11:30 a.m., with the ombudsman would expect the facility to have an updated name and contact information of the ombudsman and was to be posted in the designated areas for residents, family and visitors to see. Interview on 7/29/2025 at 11:33 a.m., with the administrator identified the facility had sent a request to the ombudsman by email for ombudsman information cards to be sent to the facility and had not received updated contact information to be shared	F0574		

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F0574 SS = C	Continued from page 3 at the facility. She acknowledged the request by email was sent a year ago. Email correspondence on 2/10/25 at 2:51 p.m., identified an email was sent to the current ombudsman for information cards to be sent to the facility, however, 167 days after the email was sent, the facility had not posted the current ombudsman information on the first, second and third floor of the facility. Review of June 2019 Federal Bill of Rights identified the facility must post written description of legal rights, in a form and manner accessible and understandable to residents and resident representatives that was to include names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the Office of the State Long-Term Care Ombudsman program.	F0574		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical	F0605	F605: Right to be free from chemical restraint How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Immediately following the information, one resident R8 Seroquel use was assessed. Education was initiated to nurses immediately related to how to ensure right DX is assigned to residents on Seroquel. How the nursing facility will identify other residents having the potential to be affected by the same practice: All residents on psychotropics have the potential to be affected by this practice. No residents have been noted to be adversely affected. Immediate review of all residents was completed. All those on psychotropics had the right diagnosis. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses and medical records training, implemented for DX identification. How does the nursing home plan monitor its performance to make sure that solutions are sustained? The Director of Nursing or Designee will audit monthly for two months. Results will be brought to QAPI for two	09/28/2025

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F0605 SS = D	Continued from page 4 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic	F0605	Continued from page 4 months or until sustained compliance occurs. Date it will be corrected: Sep 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee	

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 07/31/2025

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F0605 SS = D	Continued from page 5 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure psychotropic medication, Seroquel (antipsychotic used to treat schizophrenia, bipolar, and major depressive disorder) had an appropriate diagnosis for continued use for 1 of 1 (R8) resident reviewed for chemical restraints. Findings include: R8 was admitted October 2023. R8's 10/09/23, Pre-Admission Screening and Resident Review Results (PASARR) identified R8 had a diagnosis of urinary retention (inability to empty the bladder) and did not have a mental illness. R8's undated, current Diagnosis Report identified R8 had a diagnosis of anxiety dated 7/2023 and dementia dated 10/2023.	F0605		

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F0605 SS = D	Continued from page 6 R8's 5/21/25, quarterly Minimum Data Set (MDS) identified R8 was severely cognitively impaired and had no behaviors. R8 had little interest in doing things and felt down, depressed or hopeless never to 1 day and would sometimes socially isolate himself. R8 had taken antipsychotic, antidepressants and anticonvulsant on a routine basis. R8's undated, current Order Summary Report identified R8 was to take Seroquel (antipsychotic used to treat schizophrenia, bipolar, and major depressive disorder) 75 milligrams (mg) by mouth daily for psychosis (signs of delusions, hallucinations and/or disorganized thoughts or speech) with an order date of 9/24/24. R8's May 2025, Medication Administration Record (MAR) identified R8 had received Seroquel daily from 5/01/25 to 5/31/25. R8's June 2025, MAR identified R8 had received Seroquel daily from 6/01/25 to 6/30/25. R8's July 2025, MAR identified R8 had received Seroquel daily from 7/01/25 to 7/29/25. R8's 11/20/24, annual MDS identified R8 was severely cognitively impaired and had not completed a Level II PASARR. R8's 11/25/24, LCS Social services Qrtly/SigChange/Annual Review assessment identified R8 had a mental health issue of anxiety, was taken Seroquel and was not currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability. R8 was to take medication for depression and anxiety, including for periods of agitation and psychosis. Social service was to continue to assist as needed (PRN) with R8 psychosocial or placement needs. R8's 2/19/25, quarterly MDS identified R8 was moderately cognitively impaired and did not indicate a Level II PASAR had been completed. R8's 6/23/25, Associated Clinic of Psychology progress note identified R8 continued to exhibit behavioral and emotional symptoms that affected R8 functioning. R8 had impaired short term memory loss, depression and anxiety. R8's barrier to improvement was having lack of motivation and difficulty with coping with R8's emotions. R8 had voiced concerns of depression and loneliness. Treatment for R8 identified emotional support, family/staff therapy and education, due to	F0605		

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F0605 SS = D	Continued from page 7 R8's cognitive impairment. R8's undated, current Bedside Kardex Report identified nursing staff was to calmly redirect R8 when R8 had episodes of behaviors, provide nonpharmacological interventions, such as 1:1 conversation, reassurance/redirection, offer newspaper and visits with wife and family. Interview on 7/29/25 at 12:32 p.m., with certified nursing assistant (NA)-C identified R8 had a history of being angry towards nursing staff and acknowledged it happened on one occasion when RN-C was present on the unit. R8 was approached by NA-C and appeared to be calm and allowed the nursing staff to assist him with his personal cares. Interview on 7/29/25 at 12:40 p.m., with NA-D identified R8 would have periods of sundowning during the day and would frequently request to see his wife. R8 would become agitated towards nursing staff when he had to wait to see his wife. However, nursing staff would assist R8 to his wife on another floor for a visit and would return R8 back to his room, once done. Interview on 7/30/25 at 11:36 a.m., with licensed social worker (LSW) identified the interdisciplinary team (IDT), including the consulting pharmacist (CP) had discussions on how to manage R8's mental decline and changes in behavior that affected R8's activities of daily living. R8 was ordered Seroquel to improve R8's symptoms and mood. LSW acknowledged R8 had a history of dementia, and a Level II was not completed and was not needed for R8's use of Seroquel medication. Interview on 7/30/25 at 12:22 p.m., with consulting pharmacist (CP) identified R8 had paranoid psychosis episodes and appeared to be declining in his mental health. Suggestions of treatment was made by the IDT to help alleviate R8's sundowning and to reduce his paranoia symptoms. The decision was made to start R8 on Seroquel and identified the medication had been effective, however R8 did not have an appropriate diagnosis to support the use of the medication. Interview on 7/31/25 at 9:35 a.m., with the administrator and the director of nursing (DON) would expect IDT to continue to review and identify medication effectiveness of psychotropic used for residents. Review of June 2015 Psychoactive Medication Management policy identified the facility was to implement procedures to ensure appropriate diagnosis, indications	F0605		

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F0605 SS = D	Continued from page 8 and use for psychoactive medications. Review of July 2016, Medication Utilization and Prescribing-Clinical Protocol policy identified medications prescribed in response to an identified problem would be reviewed by the physician and nursing staff to identify indication of use, residents' age, risks, health status and existing medication regimen. Resident symptoms was to be characterized in detail to help identify if a problem exist and a diagnosis, by itself, was not justified for prescribing a medication. In addition, the physician and nursing staff was to evaluate the effectiveness of the resident's medication and address undesirable or unexpected responses to the medication based on the severity or risks of the resident's medical condition. Lastly, nursing staff was to review administration of medication that may cause adverse drug reactions to ensure they are given appropriately, for example, use of antipsychotic medications given to manage behavioral symptoms for dementia.	F0605		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority-SMHA) for 1 of 5 resident (R8) with new onset of mental illness since admission.	F0644	F644: Coordination of PASARR and assessment How the nursing facility will correct the deficiency as it relates to the resident: No residents suffered adverse effects from this practice. Immediately following the information, Resident R8 assessment was reviewed and a call & email placed to county team members for evaluation. Immediate education done with involved team members. All staff education initiated to nurses immediately related to PASRR Level 2. How the nursing facility will identify other residents having the potential to be affected by the same practice: All residents with newly evident or possible serious mental disorder, intellectual disability have the potential to be affected by this practice. No residents have been noted to be adversely affected. Immediate review of all residents with possible mental disorders was completed. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses training was implemented for PASARR Level 2. Track any changes to current residents’ dx or change of	09/28/2025

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F0644 SS = D	Continued from page 9 Findings include: R8 was admitted October 2023. R8's 10/09/23, Pre-Admission Screening and Resident Review Results (PASARR) identified R8 had a diagnosis of urinary retention (inability to empty the bladder) and did not have a mental illness. R8's undated, current Diagnosis Report identified R8 had a diagnosis of anxiety dated 7/2023 and dementia dated 10/2023. R8's 5/21/25, quarterly Minimum Data Set (MDS) identified R8 was severely cognitively impaired and had no behaviors. R8 had little interest in doing things and felt down, depressed or hopeless never to 1 day and would sometimes socially isolate himself. R8 had taken antipsychotic, antidepressants and anticonvulsant on a routine basis. R8's undated, current Order Summary Report identified R8 was to take Seroquel (antipsychotic used to treat schizophrenia, bipolar, and major depressive disorder) 75 milligrams (mg) by mouth daily for psychosis (signs of delusions, hallucinations and/or disorganized thoughts or speech) with an order date of 9/24/24. R8's 11/25/24, LCS Social services Qrtly/SigChange/Annual Review assessment identified R8 had a mental health issue of anxiety, was taken Seroquel and was not currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability. R8 was to take medication for depression and anxiety, including for periods of agitation and psychosis. Social service was to continue to assist as needed (PRN) with R8 psychosocial or placement needs. R8's 2/19/25, quarterly MDS identified R8 was moderately cognitively impaired and did not indicate a Level II PASAR had been completed. R8's undated, current Bedside Kardex Report identified nursing staff was to calmly redirect R8 when R8 had	F0644	Continued from page 9 condition to ensure procedures in place for each related to PASARR Level 2. How does the nursing home plan to monitor its performance to make sure that solutions are sustained? The Director of Nursing or Designee will mention PASSR Level 2 during monthly psych meetings and as needed. Results will be brought to QAPI for two months. Date it will be corrected: September 28, 2025 Title of the person responsible to ensure correction: Director of Nursing or Designee	

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F0644 SS = D	Continued from page 10 episodes of behaviors, provide nonpharmacological interventions, such as 1:1 conversation, reassurance/redirection, offer newspaper and visits with wife and family. Interview on 7/30/25 at 11:36 a.m., with licensed social worker (LSW) identified the interdisciplinary team (IDT), including the consulting pharmacist (CP) had discussions on how to manage R8's mental decline and changes in behavior that affected R8's activities of daily living. R8 was ordered Seroquel to improve R8's symptoms and mood. LSW acknowledged R8 had a history of dementia, and a Level II was not completed and was not needed for R8's use of Seroquel medication. Interview on 7/31/25 at 9:35 a.m., with the administrator and the director of nursing (DON) would review results of the Level I PASARR and would follow the guidance of those results for new admission but was not aware of the process for a Level II PASARR. Review of June 2015, MI/MR Pre-Admission Screening policy identified the facility was to ensure that residents admitted was appropriate for skilled services. The PASARR process identified, by assessment, to determine if a resident might have a mental illness. The admissions coordinator was to evaluate the Level I results before resident was to admit to the facility. Review of undated, Newly Evident or Possible Mental Health Disorder, Intellectual Disability, or Related concern policy identified the facility was to refer a resident for a Level II upon a significant change in status if a resident was to have a evident or possible mental health disorder, intellectual disability or related condition.	F0644		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F0689	F689: Free of accidents hazards/supervision devices How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Immediately following the information, Resident R12 care plan was assessed. Education was initiated to nurses and NARS immediately related to how to ensure that the care plan or fall interventions are followed. How the nursing facility will identify other residents	09/28/2025

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F0689 SS = D	Continued from page 11 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions to reduce fall risk were implemented for 1of 1 resident (R12) reviewed for falls. Findings include: R12's Optional State Assessment (OSA) dated 5/21/25, indicated intact cognition, did not reject cares, had hemiplegia or hemiparesis (weakness or paralysis on one side of the body), and Parkinson's disease, and required extensive assistance with transfers and toileting. R12's admission Minimum Data Set (MDS) dated 5/21/25, indicated R12 had a walker and wheelchair, fell in the last month prior to admission, and fell since admission, and R12's care area assessment (CAA) summary triggered for falls. R12's Order Summary Report indicated the following order:5/15/25, nursing order, most falls occur during the hours of 4:00 a.m. and 10:00 a.m., and will require frequent checks to increase more often, or bring your Ipad to chart outside the door when able. On other times, if husband is not present in room, please have her attend activities, come out for meals, be visible in the hallway. Please let someone know if you leave her so we have a back up plan every shift for high fall risk and safety and document noted issues.R12's IDT note dated 6/23/25, indicated R12 fell on 6/21/25 and self-transferring and fell in her room near the recliner. R12 was impulsive which causes her to feel she can do things on her own and not ask for assistance. Further, the note indicated that R12 would be encouraged to ask for assistance and to keep the door open for closer observation and was able to be in her room with the preference of being supervised, although will keep the door open if not supervised and have the call light within reach at all times. R12's Kardex report dated 7/28/25 at 2:24 p.m., indicated R12 was educated she can no longer stay in her room by herself and will sit at the nurse's station. Further, the Kardex indicated R12 could not be left alone sitting on the toilet, and an intervention dated 7/8/25, directed staff to dress R12 by 7:00 a.m., and bring R12 to the nursing station for close monitoring and R12 was aware and okay with getting up	F0689	Continued from page 11 having the potential to be affected by the same practice: 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 was completed and their care plans are being followed. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses and NAR training implemented for following plan of care. How does the nursing home plan monitor its performance to make sure that solutions are sustained? 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. Date it will be corrected: September 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee	

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F0689 SS = D	Continued from page 12 at this time. R12's care plan dated 6/4/25, indicated R12 had Parkinson's disease and interventions indicated to monitor for risk for falls. R12's care plan dated 6/4/25, indicated R12 had a history of falling and had the following interventions:5/16/25, R12 was encouraged to do activities and participate in puzzles to keep out of the room. 5/19/25, place resident at nurse's station if up in wheelchair and husband is not present.6/17/25, staff to attempt to keep R12 busy in activities and therapies when not being supervised by husband or visitors.6/21/25, R12 was educated she can no longer stay in the room by herself and was advised "when she is sleeping, eating and when there is family, and friends or company is over. Resident was able to acknowledge the education. Resident will continue to sit at the nurse's station". 6/30/25, do not leave R12 alone sitting on the toilet.6/30/25, educate R12, family, and caregivers about safety reminders and what to do if a fall occurs.7/8/25, "Staff will help to dress the resident by 7 am and bring her to the nursing station for close monitoring. Resident is aware and okay with getting up at this time."7/13/25, monitor resident for signs and symptoms of a urinary tract infection and offer more toileting. 7/14/25, Resident will be moving closer to the nurse's desk.7/14/25, sent to ER for evaluation. 7/16/25, R12's Midodrine (a medication used to treat low blood pressure) was increased due to orthostatic blood pressure drops (a drop in blood pressure from a sitting or lying position that can cause symptoms of dizziness, lightheadedness, and fainting) and therapies will add more therapy sessions to R12's schedule. R12's Witnessed Fall report dated 6/7/25 at 3:10 p.m., indicated R12 was sitting in the recliner and spouse was sitting on the bed and the nurse was setting up medications in the bathroom and within a fraction of a second, R12 fell between the recliner and the bed. R12 could not explain what she was trying to do. The note further indicated R12 makes abrupt and unsafe transfers that happen too quickly to intervene. R12's Unwitnessed Fall report dated 6/17/25 at 11:45 a.m., indicated the nurse heard noises in R12's room and R12 was found on the floor between the head of the bed and the nightstand. R12 stated she was trying to water her plants and lost her balance. R12 sustained a cut to the back of her head and an order was received to send to the ER for further evaluation. R12's Unwitnessed Fall report dated 6/21/25 at 8:00	F0689		

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F0689 SS = D	Continued from page 13 a.m., indicated R12 fell when ambulating unassisted near the recliner. R12 was educated she could no longer stay in her room by herself unless she was sleeping or eating and when there was family, friends or company visiting. R12's Unwitnessed Fall report dated 6/30/25 at 4:20 a.m., indicated a nursing assistant reported that R12 was on the floor in the bathroom. R12 fell when coming back from using the toilet. R12's Unwitnessed Fall report dated 6/30/25 at 10:50 a.m., indicated after R12's friend visited, R12 was found in her room sitting on the floor and was going to use the bathroom. R12's Unwitnessed Fall report dated 7/8/25 at 7:40 a.m., indicated a nursing assistant alerted the nurse R12 was on the floor. R12 was found lying on the bathroom floor face up and did not have shoes on. The note further indicated R12 sustained a laceration to her chin and had swelling to her left eye and the whole left side of her face. R12 was sent to the ER. Further, the nursing team will help R12 get ready for the day by 7:00 a.m., and bring her to the nursing station for close monitoring for safety and R12 was agreeable to this plan due to R12 forgetting to use the call light and wait for assistance. R12's Unwitnessed Fall report dated 7/13/25 at 10:10 a.m., indicated R12 had an unwitnessed fall in her bathroom when she was trying to get from the toilet. R12's Unwitnessed Fall report dated 7/14/25 at 10:55 a.m., indicated R12's spouse notified nursing R12 was in bed sleeping and a loud noise was heard and R12 was found sitting at the back side of her bed and could not state what she was doing. R12's Unwitnessed Fall report dated 7/14/25 at 11:05 p.m., indicated a loud sound came from R12's room and R12 was located under the sink in a pool of blood and was taken to the hospital. R12's Unwitnessed Fall report dated 7/16/25 at 7:30 a.m., indicated R12 was found on the floor at the nursing station. R12 stated she got tired sitting down and wanted to stand. During observation on 7/28/25 at 2:52 p.m., R12 was in the hall by the nurse's station in her wheelchair and started to stand on her own and an unidentified staff person came up and told R12 to sit down. R12 had bruising to the left side of her face around her nose	F0689		

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F0689 SS = D	Continued from page 14 and left side of mouth and her left upper eye lid. The staff person placed R12's bedside table in front of her that had a book and a magnifying glass sitting on top of the table. During continuous observation on 7/30/25 between 7:19 a.m., and 7:30 a.m., R12 was located in her room in her wheelchair. R12 had her call light and a bell was located on the bedside table. R12 was dressed and had her shoes on and was alone in her room playing with her call cord. At 7:26 a.m., R12 was propelling herself out of site and surveyor entered R12's room and observed R12 going into the bathroom. R12's bathroom was not visible from outside her room. R12 stated she had Parkinson's and fell a lot and stated staff were working on getting notices regarding falls. At 7:30 a.m., R12 did not have staff inside her room. During interview on 7/30/25 at 7:30 a.m., registered nurse (RN)-C was asked if R12 could be in the room by herself, but RN-C was unable to log into his computer and asked nursing assistant (NA)-A. NA-A stated since they were getting people up, they can check on her. At 7:33 a.m., NA-A stated she looked at the therapy book to know what cares a resident required. NA-A and RN-C looked in the therapy book, but could not locate an evaluation for R12. During interview on 7/30/25 between 7:33 a.m., and 7:35 a.m., NA-B stated she had to leave R12 in her room and added R12 could not be left alone when nobody was there. At 7:35 a.m., NA-B verified R12 was in her room by the bathroom door. During interview on 7/30/25 between 7:36 a.m., and 7:37 a.m., NA-A stated she had access to R12's medication orders because she was also a trained medication aide. NA-A viewed the nursing order that indicated most falls occurred between 4:00 a.m., and 10:00 a.m., and R12 required frequent checks so they just lay eyes on her if her husband was not present in the room and further stated they had R12 attend activities, but activities did not start until 9:30 a.m. and added R12 had to come out for meals however it was not time for breakfast and R12 had to be visible in the hallway. At 7:37 a.m., NA-B brought R12 out of her room and asked if someone could be with R12. RN-C stated R12 had to be visible from the hallway and NA-A stated R12 should be in the hallway and added as long as they can see her. During interview on 7/30/25 at 7:53 a.m., RN-B stated NA's used a Kardex to know what cares a resident required and did not carry a paper and added they can look at their tablets. RN-B stated R12 fell 5 to 6	F0689		

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F0689 SS = D	Continued from page 15 times a day prior to admission and still had a lot of falls because R12 had Parkinson's disease and was impulsive. RN-B stated staff had to keep a close eye on R12 and added if R12 was in her room, would try to get up and tried to have the wheelchair next to her, keep R12 at the desk or with staff during the day and in activities. RN-B further stated R12 liked to take naps and loved being social and enjoyed hanging out with everyone. RN-B stated R12's worst time was in the morning. RN-B stated if R12 was visible and staff could check on her, R12 could be in her room and added R12 never asks to be in her room and is set up by the nursing station. RN-B viewed R12's care plan and verified intervention R12 could no longer stay in her room by herself and added if the intervention was resolved it should not be located on the care plan. During interview on 7/30/25 at 8:49 a.m., the director of nursing (DON) stated he expected R12 be out in the nurse's station and stated R12 was impulsive and added it would be important to implement the interventions and was important for R12 to be out of her room when in the wheelchair to prevent her from falling. During interview on 7/30/25 at 9:50 a.m., the DON provided a progress note dated 6/23/25 at 11:24 a.m., that indicated IDT met to discuss the fall on 6/21/25 and clarified that R12 was able to be in her room with the preference of being supervised, although will keep the door open. During interview on 7/30/25 at 1:01 p.m., the DON verified the care planned intervention dated 7/8/25, that indicated staff were to dress and bring R12 to the nurse's station. A policy, Fall Prevention, dated 7/2018, indicated the fall prevention program shall identify residents who are at risk for falls, identify precipitating events that have led to falls, identify patterns in falls, and implement interventions to prevent or reduce the incidence of falls.	F0689		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0757	F757: Drug regimen is free from unnecessary drugs How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Immediately following the information, 2 Resident, R43 and R48, orders were reviewed and were assessed. Education was initiated to nurses immediately related to how to ensure that the PRN orders are discontinued or reviewed for unnecessary usage.	09/28/2025

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F0757 SS = D	Continued from page 16 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure orders for an as needed (PRN) medications for 2 of 5 (R43 and R48) either discontinued after 14 days or indications for extending the medication for use greater than 14 days reviewed for unnecessary medications Findings include: R43 R43's undated, current diagnoses list identified R43 had heart failure, chronic kidney disease, muscle weakness, diabetes, pain, and fracture of head of right radius (two long bones on the forearm). R43's 7/02/25, Significant Change Minimum Data Set (MDS) identified R43 was severely cognitively impaired and had received scheduled pain medication. R43 was on hospice services. R43's undated, care plan identified R43 had a terminal prognosis/end stage condition related to heart failure. Interventions was for nursing staff to observe resident for signs of pain, administer pain mediation and notify the physician of breakthrough pain.	F0757	Continued from page 16 How the nursing facility will identify other residents having the potential to be affected by the same practice: 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 that are using PRN was completed and plans of care being followed. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses and NAR training implemented for stop dates/unnecessary medications. How does the nursing home plan monitor its performance to make sure that solutions are sustained? 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. Date it will be corrected: September 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee	

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 07/31/2025

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F0757 SS = D	Continued from page 17 R43's June 2025, Medication Administration Report (MAR) identified R43 was to take morphine sulfate 15 milligrams (mg), give 5 mg by mouth every 1 hours as needed for shortness of breath (SOB) and pain, with a start date of 6/26/25. However, the order lacked an end date and the medical record did not identify a rationale for continued use of the medication. R48 R48 was admitted July 2025. R48's undated, current diagnoses identified R48 had artificial hip joint, osteoarthritis (cartilage that cushions the end of the bones that causes pain, stiffness and decreased in flexibility), and fracture of right humerus (head bone of the shoulder). R48's Order Summary Report identified R48 was to take amoxicillin 2,000mg by mouth as needed for fractured arm, with a start date of 7/21/25. However, the order lacked an end date and the medical record did not identify a rationale for continued use of the medication. R48's undated, current care plan identified that R48 had an infection related to foley catheter (flexible tube that is inserted in the bladder to drain urine) placement and recurrent urinary tract infections (UTI). Interventions was for nursing staff to follow infection precautions as directed by the physician and observe for signs or symptoms of worsening infection and notify the physician of changes. Interview on 07/30/2025 at 12:30 p.m., with consultant pharmacist (CP) identified PRN orders was to have a stop date in place and would expect clarification on the order for the continued use of the medication. Interview on 7/31/25 at 9:10 a.m., with director of nursing (DON) had voice agreement that R43 and R48 PRN medications should have a stope date or rationale for continued use after 14 days. Review of July 2016 Medication Utilization and Prescribing-Clinical Protocol policy identified the	F0757		

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F0757 SS = D	Continued from page 18 facility physician and nursing staff was to review the rationale for existing medications that lack an indication or was being used intermittently on a PRN basis.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were labeled with appropriate administration instructions for 2 of 5 residents (R3,R29) observed during medication administration observations. R3's annual Minimum Data Set (MDS) dated 5/14/25, indicated R3 was cognitively intact, required partial assistance to independent for most activities of daily living (ADLs), and had diagnoses of essential hypertension, anxiety, and dementia. R3's physician orders dated 3/21/24, indicated, "amlodipine besylate oral tablet 2.5mg [a calcium channel blocker used to lower blood pressure] Give	F0761	F761: Label/store drugs and biologicals How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Immediately following the information, two resident R3 and R29 labels were reviewed for appropriate administration instructions. Corrected administration instructions. Education was initiated to nurses and TMAs immediately related to how to ensure that the labels match med administration instructions. How the nursing facility will identify other residents having the potential to be affected by the same practice: 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 was completed and their labels are matching. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses and TMA training implemented for storage and labeling. How does the nursing home plan monitor its performance to make sure that solutions are sustained? 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. Date it will be corrected: September 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee	09/28/2025

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F0761 SS = D	Continued from page 19 2.5mg by mouth in the evening related to ESSENTIAL [PRIMARY] HYPERTENSION." R3's order report dated 5/9/24, indicated, "amlodipine besylate oral tablet 2.5mg Give 2.5mg by mouth one time a day related to ESSENTIAL [PRIMARY] HYPERTENSION." Directions for administration indicated, "1 TAB BY MOUTH EVERY EVENING." The order report indicated date last dispensed and received was 7/22/25. R3's July 2025, medication administration record (MAR) indicated Amlodipine Besylate was scheduled to be administered "*AM 7." R29's quarterly MDS dated 6/25/25, indicated R29 had severe cognitive impairment, was dependent on others for most ADLs, and had diagnoses of hemiplegia and hemiparesis (weakness and paralysis affecting one side of the body), dementia, history of cataract extraction from both eyes, and aphasia (condition affecting ability to speak). R29's January 2025 MAR indicated, "Refresh Tears Ophthalmic Solution...Instill 2 drops in left eye every 4 hours as needed for dry eye discontinue order when resolved.-Start date 8/11/24 -DC date 1/14/25." R29's July 2025 MAR indicated, "Refresh Tears Ophthalmic Solution...Instill 2 drop [sic] in left eye two times a day for dry eye Two eye drops in the left eye twice a day.-Start date 1/14/25." MAR indicated administration "*AM 7" and "*Even." R29's physician orders dated 1/14/25, indicated, "Refresh Tears Ophthalmic Solution...Instill 2 drop [sic] in left eye two times a day for dry eye Two eye drops in the left eye twice a day." During observation on 7/30/25 at 7:12 a.m., registered nurse (RN)-A punched out an amlodipine tablet from the medication card and placed in medicine cup for administration. Review of the medication card indicated medication to be given once a day in the evening. During interview on 7/30/25 at 7:24 a.m., RN-A stated only medications scheduled during the current shift show up on the MAR and the amlodipine had a scheduled time of 7a – 11a. RN-A could not explain why the instruction on the medication card indicated an evening administration. During interview on 7/30/25 at 7:55 a.m., RN-A could not explain why the new order from 5/9/24 was not indicated on the medication card and was only showing	F0761		

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F0761 SS = D	Continued from page 20 up on MAR and orders. During interview on 7/30/25 8:01 a.m., licensed practical nurse (LPN)-B could not explain why the medication card did not match the MAR and stated she would locate the original admission order. LPN-B stated would expect nurses to check the medication instructions prior to administration. During observation on 7/30/25 at 8:08 a.m., LPN-A collected R29's morning medications for administration. All oral medications were crushed and administered in applesauce. R29's eye drops label indicated "Instill 2 drops into left eye every 4 hours as needed." During interview on 7/30/25 at 8:56 a.m. LPN-B stated she just spoke to R3's physician who just gave the order for R3's amlodipine to be given in the morning since her blood pressures had been stable. LPN-B further stated R3's order summary from May 2024 indicated the medication was to be administered every day and would not confirm the administration directions instructed the medication to be given in the evening. During interview on 7/30/25 at 8:57 a.m., director of nursing (DON) stated expectation for nurses to verify the order if the medication card did not match the order in the MAR. During follow up interview on 7/30/25at 9:18 a.m., DON stated the inaccurate labels should have been identified before now and nurse education had already started. During interview on 7/30/25 at 9:28 a.m., consultant pharmacist (CD) stated the discrepancy should have been caught before now. CD further stated could confirm the special instructions from the original order would still be listed on the medication card until a new order was received to discontinue the original order and a new order provided. During interview on 7/30/25 at 10:56 a.m., LPN-A stated the label on the medication or medication card should match the order in the MAR and if a discrepancy was identified, the nurse should verify the order with the pharmacy or provider. During interview on 7/30/25 at 11:04 a.m., LPN-B verified all medication labels and medication cards should have correct information and instructions and should match the order in the chart. If a discrepancy was identified, the nurse should verify with pharmacy and will request a new label.	F0761		

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F0761 SS = D	Continued from page 21 During interview on 7/30/25 at 12:02 p.m., RN-C described the medication refill process for eye drops and stated the baggie in which the eye drops would have been received and stored in would have a sticker attached to be used to reorder. The sticker would be removed and placed on a pharmacy communication sheet and faxed to the pharmacy. During interview on 7/30/25 at 12:14 p.m., LPN-A stated medication refills could be processed three different ways. The order could be handwritten on an order sheet and send the duplicate sheet to pharmacy. They could use the sticker that should be on the medication and faxed to pharmacy. Or they could just click a button in the MAR which would send a message straight to the pharmacy. During follow up interview on 7/30/25 at 12:38 p.m., CP confirmed there were three different ways the facility could reorder medications for refill and could not explain why there was not one standard. Facility policy Administering Medications dated April 2019, indicated, "The individual administering the medication checks the label THREE [3] times to verify the right resident, right medication, right dosage, right time and right method [route] of administration before giving the medication." Facility policy Medication Labeling and Storage dated February 2023, indicated medication labels dispensed by a pharmacy must comply with state and federal regulations. The policy further indicated, "The medication label includes, at a minimum...g. appropriate instructions and precautions." The policy indicated, "If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items." The policy instructed nursing staff to inform the pharmacy of any changes in orders for medications.	F0761		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives	F0883	F883: Influenza and pneumococcal immunizations How the nursing facility will correct the deficiency as it relates to the residents: No residents suffered adverse effects from this practice. Immediately following the information, two residents, R17, and R21 immunizations, were assessed. Resident R17 had been offered pneumococcal vaccine on 7/8/21 (and again on 7/31/25) and declined. Resident R21 had been offered pneumococcal vaccine on 9/13/24	09/28/2025

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F0883 SS = D	Continued from page 22 education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883	Continued from page 22 and 6/3/22 and declined (and offered again on 7/31/25 with acceptance). Education was initiated to nurses immediately related to how to ensure that immunizations are offered and documented. How the nursing facility will identify other residents having the potential to be affected by the same practice: 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 was completed and their immunizations current or have been offered. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not recur: Nurses training implemented for following immunization protocols. How does the nursing home plan monitor its performance to make sure that solutions are sustained? 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. Date it will be corrected: September 28, 2025 Title of the person responsible for ensuring correction: Director of Nursing or Designee	

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F0883 SS = D	Continued from page 23 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 (R17, and R21) were offered and or provided updated vaccination for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include: A Centers for Disease Control (CDC) form, Pneumococcal Vaccine Timing for Adults dated March 2025, indicated for adults greater than 50 years old with prior PCV13 at any age and PPSV23 at less than 65 years old to administer PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Further, for adults who completed a PCV13 at any age and a PPSV23 at 65 years or older indicated together with the patient, vaccine providers may choose to administer PCV20 or PCV21 to adults greater than 65 years old who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old. R17, R17's Facesheet printed 7/31/25 at 9:59 a.m., indicated R17 admitted to the facility on 7/6/21, and was 86 years' old and birthdate was 8/15/1938. R17's quarterly Minimum Data Set (MDS) dated 7/2/25, indicated R17's pneumococcal vaccinations were up to date. R17's Order Summary Report indicated the following order, 3/22/24, may use physician approved standing orders. R17's Minnesota Immunization Information Connection (MIIC) report dated 4/24/25, indicated R17 received Prevnar 13 (PCV13) on 10/9/13, and 10/9/14. Additionally, R17 received PPSV23 on 8/18/2003. No additional pneumovaccinations were documented on the MIIC as administered. Further, the form indicated the pneumovaccinations were complete. R17's MIIC report dated 7/31/25, indicated R17 received Prevnar 13 (PCV13) on 10/9/13, and 10/9/14. Additionally, R17 received PPSV23 on 8/18/2003. No additional pneumovaccinations were documented on the MIIC as administered. R17's Immunizations form dated 7/31/25, indicated R17 received PCV13 on 10/9/13, and 10/9/14, and the PPSV23	F0883		

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F0883 SS = D	Continued from page 24 on 8/18/2003. R17's Nursing Home Visit noted dated 7/14/25, indicated R17 had a past medical history of Alzheimer's disease, respiratory failure, and pneumonia, had worsening dementia and family and R17 decided on comfort measure and hospice, however R17's respiratory status improved as did her mental status and did not meet criteria for hospice. The note further indicated no immunizations were recorded for R17 and R17 had no known drug allergies. R17's record was reviewed and lacked information R17 consented to or declined PCV20 or PCV21 vaccination or that a shared clinical decision-making discussion occurred. R21 R21's face sheet dated 7/31/25, indicated R21was admitted on 5/26/22, and was 89 years old and birthdate was 4/5/1936. Further, R21 had shortness of breath, and hemiplegia and hemiparesis following cerebrovascular disease. R21's quarterly MDS dated 5/14/25, R21's pneumococcal vaccinations were up to date. R21's Order Summary Report indicated an order dated 6/29/22, may use physician approved standing orders. R21's MIIC report dated 7/31/25, indicated R21 received PCV13 on 5/22/17, and PPSV23 on 6/4/13. R21's Immunization form dated 7/31/25 at 1:16 p.m., indicated R21 received PCV13 on 5/22/2017, and PPV23 on 6/4/13. R21's Nursing Home Visit note dated 7/14/25, indicated no known drug allergies, and no immunizations were recorded for R21. R21's record was reviewed and lacked information R21 consented to or declined PCV20 or PCV21 vaccination or that a shared clinical decision-making discussion occurred. During interview on 7/30/25 at 1:05 p.m., the infection preventionist (IP) who was also the director of nursing (DON) stated they reviewed the CDC guidelines to determine what kind of pneumovaccine was needed for residents. Further, residents signed a declination or a consent form for a pneumovaccine and was in the	F0883		

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F0883 SS = D	Continued from page 25 resident chart or immunization part of the electronic medical record (EMR) and added best practice was to document the consent under the Immunizations tab in the EMR if it was not under the scanned documents. Further, the DON stated they also looked at the MIIC and input the information from the MIIC report. The DON viewed R17's vaccinations and verified R17 received PCV13 on 10/9/14, and PPV23 on 8/18/2003, and verified there were no additional vaccinations provided and the DON reviewed R17's documents and stated he did not locate a consent or declination for pneumovaccinations for R17 and viewed the MIIC and verified there were no recent immunizations either. The DON viewed R21's Immunizations tab and MIIC report and verified R21 had PCV13 on 5/22/2017, and PPV23 on 6/4/13. The DON stated he thought R21 declined the vaccine and viewed R21's Vaccine Administration Record form and under a section that identified which vaccines the resident wanted, nothing was documented. At 1:41 p.m., registered nurse (RN)-B entered the DON's office, and the DON asked RN-B if there was any discussion that occurred with residents or consent for PCV20 or PCV21 and RN-B stated it was up to the physician and added she did not know if the physician had a conversation. Documentation demonstrating decision making occurred, along with declination or consent forms were requested. During interview on 7/31/25 at 8:11 a.m., the DON stated he did not have any additional immunization information. During interview on 7/31/25 at 8:30 a.m., the DON stated he spoke with the physician who was going to look at the vaccinations but did not ask the residents regarding whether they would want vaccination and further stated the physician directed the DON to obtain consent forms or declinations and let him know their decisions and the physician would follow up on 8/4/25. The DON further stated he spoke with licensed practical nurse (LPN)-B this morning to obtain the consents or declinations. The DON later provided informed consent forms dated 7/31/25, for both R17 and R21 that indicated both R17 and R21's legal representative requested pneumococcal vaccination. A form, Vaccine Information Sheet Pneumococcal Conjugate Vaccine, from the Centers for Disease Control (CDC) indicated pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are three pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20). A form, TCU and LTC Standing House Orders dated 5/16/23, indicated may administer pneumococcal	F0883		

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F0883 SS = D	Continued from page 26 vaccination (PPSV23 or PCV13) per CDC guidelines to patients who have not received unless contraindicated. The form lacked information for administering PCV20 or PCV21. A policy, Pneumococcal Vaccine, dated 10/2023, indicated all residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine and provision of such education is documented in the resident's medical record. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician approved pneumococcal vaccination protocol. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control (CDC) recommendations at the time of the vaccination.	F0883		

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 07/29/2025

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

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/29/2025, 2018. At the time of this survey, The Birches at Trillium Woods was found 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, the Health Care Facilities Code. (Building Info) 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. The facility has a capacity of 44 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K0000		

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