STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birches at Trillium Woods	14585 59th Avenue North Plymouth, MN 55446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 40 residents currently residing in the facility as well as all staff and visitors.Findings include: On 5/27/26 at 7:27 a.m. displayed next to double doors to enter first floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:52 a.m. displayed next to double doors to enter second floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 7:56 a.m. displayed next to double doors to enter third floor unit was the RBOR, dated 4/14/09. On 5/27/26 at 8:26 a.m. administrator stated they were not aware there were changes to the RBOR. At 9:21 a.m. administrator returned, stated they have now started the process of providing updates to the residents and resident representatives. They have not yet ordered new postings for the units. Facility Resident Resident Rights policy dated 10/24, indicated copies of the resident rights was posted throughout the facility, however, the policy did not indicate when the facility would provide notification of any changes in any State of Federal laws related to resident rights or facility rules during the residents stay in the facility.

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 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birches at Trillium Woods	14585 59th Avenue North Plymouth, MN 55446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure all residents were offered written notice for bed hold for 1 of 3 residents (R7) who were reviewed for discharges / transfers from the facility. Findings include - In review of R7's admission Record (print date 5/27/26), documented were the following diagnoses: effusion right elbow (a buildup of excess fluid within the elbow joint capsule), peripheral vascular disease, and end stage real disease with dependence on dialysis. A review of R7's most recent quarterly Minimum Data Set (MDS) dated [DATE], documented R7 was cognitively intact and required substantial - maximal assistance with activities of daily living. In review of R7's electronic medical records (EMR), Resident's progress notes documented the facility received a phone call at 12:00 p.m., from R7's dialysis unit, reporting resident should be seen in the emergency room (ER) due to experiencing pain in her right arm. R7's primary clinic was updated and orders received to send resident to the ER upon her return to the facility. After returning to the facility at 2:10 p.m., the facility sent R7 to the ER for further evaluation. The facility received a call later that evening from Methodist Hospital, informing the facility R7 had been admitted for further testing and MRI (Magnetic Resonance Imaging is a non-invasive medical test that uses powerful magnets and radio waves to create detailed, cross-sectional images of your body's organs, tissues, and skeletal system). Resident returned to the facility on 5/9/26, 3 days later. During an interview on 05/26/2026 at 2:05 p.m., R7 stated she had gone to the hospital earlier in the month but could not remember if she had been offered or signed a bed hold for the transfer. In further review of R7's EMR, there was no evidence the facility had offered resident a bed hold in writing. During interview on 5/27/26 at 10:21 a.m., the facilities licensed social worker (LSW) stated, when residents are transferred to the hospital, the resident, family / significant other are offered a bed hold, which is reviewed with them and is signed if a bed hold is requested. LSW stated until the forms are scanned into the EMR, they are located in the resident's paper hard chart at the nurses station. A review of R7's hard paper chart lacked evidence R7 and / or her family were offered a bed hold in writing. In a interview on 5/27/26 at 2:10 p.m., the director of nursing (DON) stated the staff might not have offered a bed hold while it is the courtesy of the corporation to hold a bed when someone goes to the hospital. During an interview on 5/27/26 at 3:43 p.m., both the DON and the administrator (ADM) stated they were unable to locate a signed / written bed hold for the 5/6/26 hospitalization of R7. Both the DON and ADM stated it would be the facility's expectation a bed hold be offered either to the resident and/or their family. In review of the facility's admission Packet (undated), the following was documented: Section 6. BED HOLD POLICY, if you are absent from the Health Center, we shall hold your bed in accordance with our current bed hold policy. A copy of the current bed hold policy is included in these documents listed in the attached Checklist, We reserve the right to change our bed hold policy from time to time in accordance with applicable laws and regulations. A copy of the current bed hold policy shall be provided to you and your family member or legal Representative, Responsible party, or Resident Representative before your transfer. In review of the facility's Policy and Procedure form, entitled: Trillium Woods Policy and Procedure - Bed Hold / Leave of Absence Policy and Acknowledgement (undated), documented three types of resident stays, each with different requirements and time lines for bed hold: Medicare or Private Pay Resident, Medicaid Resident and Life Care Resident on the same form. However, for each resident stay type, the document read, Resident (and/or Resident's legal Representative, if applicable) hereby acknowledge(s) receipt of the Health Center Bed Hold Policy, with a line for a signature and date signed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birches at Trillium Woods	14585 59th Avenue North Plymouth, MN 55446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure provider orders were followed which caused pain for 1 of 1 residents (R58) reviewed.Findings include: R58's admission Minimum Data Set (MDS) dated [DATE], indicated R58 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs). R58's diagnoses included presence of artificial hip joint, anxiety, pain, femur fracture, and Alzheimers disease R58's care plan revised 5/6/26, indicated R58 was on pain medication therapy related to hip surgery, the care plan included an intervention to administer medications as ordered. During interview on 5/26/26, at 3:37 p.m. family member (FM)-A stated they had asked for lidocaine to be applied to R58's skin before she was given her injection to help decrease the pain it caused her. FM-A stated the nurses were not consistently doing the lidocaine before the injection, some were doing it after, some were not doing it at all, some would put it on one area then do the injection somewhere else. On 5/26/26, at 3:51 p.m. licensed practical nurse (LPN)-A entered R58's room to administer R58's injection, FM-A asked LPN-A if the lidocaine was going to be applied before the injection was given so she has less pain, LPN-A stated to FM-A no, we put it on after to take away the pain FM-A stated no, the lidocaine was supposed to be put on at least fifteen minutes before so she doesn't feel the injection, LPN-A repeated the lidocaine was put on after. LPN-A proceeded to give the injection, R58 screamed out ouch, ouch don't do that you jerk' while striking out at the nurse. R58's electronic medical record (EMR) was reviewed, the EMR indicated R58 had orders for:Lidocaine external gel 4% (local anesthetic applied to the skin to temporarily numb the area) apply thin layer to the area enoxaparin injection thirty minutes prior to injection once daily.Enoxaparin sodium injection solution prefilled syringe 40millegram(mg)/0.4milliliters (ml) (prescription blood thinner) inject 0.4ml subcutaneously (subq) one time daily. On 5/27/26, at 9:54 a.m. registered nurse (RN) - A removed an enoxaparin sodium injection solution prefilled syringe from R58's medication cabinet, RN-A administered the injection into R58's abdomen, R58 screamed out ouch, damn it you jerk, that hurt resident continued yelling at RN-A, grabbed RN-As arm then scratched the back of RN-A's hand. Staff offered R58 breakfast, R58 stated I don't want breakfast damn it. When interviewed on 5/27/26, at 10:22 a.m. RN-A stated they would reapproach R58 to apply the lidocaine gel to the injection site after R58 had time to calm down from getting upset after the injection. RN-A stated it would not be a good idea to try it now due to R58 was too upset and would not allow her to apply the gel. RN-A reviewed R58's EMR then stated oh I should have applied that before the injection was done, I did not do it. When interviewed on 5/27/26, at 2:19 p.m. director of nursing (DON) stated the expectation was for nurses to review the residents' orders prior to administering medications to ensure they were correctly administering the medications as they were ordered by the provider. DON stated applying the lidocaine after the injection would not help R58 with the pain from administration. Facility policy Pain Assessment and Management dated 2001. indicated staff to observe from behavioral signs of pain which included negative verbalizations and vocalizations such as groaning, crying and screaming; be3havior such as resisting care, irritability decreased participation in usual physical/social activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birches at Trillium Woods	14585 59th Avenue North Plymouth, MN 55446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and document review, the facility failed to ensure residents were free of medication errors of less than 5% for 1 of 2 residents (R58) observed for medication administration resulting in a 7.69% error rate.Findings include: R58's electronic medical record (EMR) was reviewed, the EMR indicated R58 had orders for:Lidocaine external gel 4% (local anesthetic applied to the skin to temporarily numb the area) apply thin layer to the area enoxaparin injection thirty minutes prior to injection once daily.Enoxaparin sodium injection solution prefilled syringe 40millegram(mg)/0.4milliliters (ml) (prescription blood thinner) inject 0.4ml subcutaneously (subq) one time daily administer lidocaine prior to injection. R58 was observed on 5/27/26, at 9:54 a.m. during a medication pass. Registered nurse (RN) - A removed an enoxaparin sodium injection solution prefilled syringe from R58's medication cabinet, RN-A administered the injection into R58's abdomen. On 5/27/26, at 10:22 a.m. RN-A stated she would approach R58 in about five minutes and apply the lidocaine gel. RN-A reviewed R58's EMR and stated, oh I should have applied that before the injection was done, I did not do it. When interviewed on 5/27/26, at 2:19 p.m. director of nursing (DON) stated the expectation was for nurses to review the residents' orders prior to administering medications to ensure they were correctly administering the medications as they were ordered by the provider. Facility Administering Medications policy stated 4/19, indicated medications were administered in accordance with prescriber orders, this included any required time frame.