Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

April 8, 2026

Licensee
Trillium Woods Assisted Living
5867 Cheshire Parkway North
Plymouth, MN 55446

RE: Provisional Conditional License Number 422483
Health Facility Identification Number (HFID) 40984
Project Number(s) SL40984015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 7, 2026**.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $4,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

CONDITIONAL LICENSE ISSUED:

MDH will issue Trillium Woods Assisted Living a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Trillium Woods Assisted Living is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Trillium Woods Assisted Living will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Trillium Woods Assisted Living must provide the Department:

i. A list of the names and birthdates of any individuals Trillium Woods Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
    1. Name and birthdate of each resident
    2. Current payment source for services
    3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Trillium Woods Assisted Living to correct the violations cited during the survey as well as to determine the overall practice of Trillium Woods Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

e. **Corrective Action Plan:** Trillium Woods Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Trillium Woods Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Trillium Woods Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Trillium Woods Assisted Living. If MDH determines Trillium Woods Assisted Living is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after

provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917 or email at: Casey.DeVries@state.mn.us.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40984015-0 On February 2, 2026, through February 5, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 20 residents, all of whom received services under the Provisional Assisted Living Facility license. An immediate correction order was identified on February 4, 2026, issued for SL40984015-0, tag identification 1290 and 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 (a) Staff records	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
0 650	Continued From page 1 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-B, ULP-H) who worked with oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
0 650	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired to the parent company of the licensee on August 14, 2023, to provide assisted living services and began working for the licensee on October 14, 2025, when the first resident was admitted. ULP-B's personnel file included a Department Orientation Checklist completed April 4, 2025, which included oxygen training. ULP-B's record lacked a return demonstration competency evaluation for oxygen. R8's Treatment Administration Record dated January 1, 2026, through January 31, 2026, indicated ULP-B administered 2 L of oxygen on January 11, 22, and 28, 2026. ULP-H ULP-H was hired on September 22, 2025, to provide assisted living services. ULP-H's personnel file included a Department Orientation Checklist completed October 13, 2025, which included oxygen training. ULP-H's record lacked a return demonstration competency evaluation for oxygen. On February 3, 2026, at 11:41 a.m., ULP-B stated they were trained by a nurse on oxygen, and the nurse watched them perform oxygen management tasks. On February 4, 2026, at 9:58 a.m., R2 stated they used oxygen when they needed it. The surveyor	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
0 650	Continued From page 3 observed a concentrator, a large liquid oxygen tank, and an oxygen cylinder. R2 was utilizing the oxygen cylinder. R2 stated some staff did not know how to assist them with oxygen when they asked for assistance, so they would wait for the nurse to assist. R2 stated there were certain ULP they avoided when they needed oxygen assistance. On January 4, 2026, at 10:42 a.m., clinical nurse supervisor (CNS)-C stated they were unaware ULP were assisting with oxygen management, and they believed ULP were contacting the onsite registered nurse (RN) anytime a resident needed oxygen assistance. On February 5, 2026, at 8:09 a.m., ULP-H stated R2 used their oxygen when they were short of breath. ULP-H stated R2 called for help when they need assistance with oxygen, and they would assist R2 by turning on the oxygen. ULP-H stated they set R2's oxygen to 2 liters (L) as previously instructed by registered nurse (RN)-A and checked the nasal cannula to make sure the oxygen flowed through the tubing. ULP-H stated they were trained by RN-A on oxygen administration, and RN-A watched them complete oxygen administration, "to see if I was ok to do it." On Thursday February 5, 2026, at 3:59 p.m., via email, CNS-C wrote, "I wanted to highlight that we did not have Oxygen competency for [ULP-B] and [ULP-H]". The licensee's undated Delegation of Nursing Tasks - "Treatment and Therapy" policy indicated the registered nurse (RN) would verify the ULP was trained and competent and was instructed in the proper methods to perform the task with respect to the specific resident, and the RN or	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
0 650	Continued From page 4 other appropriately licensed staff would document any ULP trainings and/or competencies. The licensee's undated Personnel Records policy indicated personnel files would include a record of all required training for unlicensed personnel and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and a clearance letter was received for 3 of 69 employees (unlicensed personnel	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01290	Continued From page 5 (ULP)-F, M-G and ULP-I) and failed to ensure 64 of 66 employees were affiliated with the licensee's current health facility identification number (HFID#) 40984. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired on November 10, 2015, under the parent company's former comprehensive license, began providing assisted living services with the parent company on on August 1, 2021, and began providing assisted living services in the licensee's facility on October 14, 2025, when the first resident was admitted to the facility. M-G M-G was hired on June 23, 2015, to provide maintenance to the parent company's facilities, and transitioned to the licensee's facility on October 14, 2025, when the first resident was admitted to the facility. ULP-I ULP-I was hired on September 22, 2025, under the parent company's assisted living licensure, and began providing assisted living services in the licensee's facility on October 14, 2025, when the first resident was admitted to the facility. On February 3, 2026, at 9:34 a.m., via email, the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01290	Continued From page 6 surveyor received the licensee's undated NetStudy 2.0 roster (web-based system used by the Minnesota Department of Human Services (DHS) to submit and process background study requests). The document lacked the licensee's HFID#. The surveyor did not see ULP-F, M-G, or ULP-I on the NetStudy 2.0 roster. On February 3, 2026, at 8:38 p.m., via email, the surveyor received the licensee's undated NetStudy 2.0 Roster for HFID# 40984. The document lacked the date affiliations to the HFID# occurred. On February 4, 2026, at 7:38 a.m., the surveyor observed the NetStudy 2.0 website and observed the following: - ULP-F separated from three different license numbers, none of which included the licensee; - M-G no background studies were conducted; and - ULP-I affiliated to the licensee's HFID# on February 2, 2026, during the survey. On January 4, 2026, at 8:00 a.m., via email, the surveyor received the licensee's undated NetStudy 2.0 Roster for HFID# 40984 which included the dates of affiliation. The surveyor compared the NetStudy 2.0 roster to the licensee's staff list and observed the following: Employees not listed on any of the three NetStudy 2.0 rosters listed above: - ULP-F; - M-G; - ULP-I; and, in addition, - 64 employees that were affiliated with the licensee's HFID# 40984 on February 2, 2026, and February 3, 2026, completed during the survey. On February 4, 2026, at 9:40 a.m., licensed	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01290	Continued From page 7 assisted living director (LALD)-D stated their human resource department was responsible for conducting background studies on all employees. On February 4, 2026, at 10:42 a.m., the surveyor received time clock entries for ULP-F, M-G, and ULP-I, which indicated the following: - ULP-F worked February 2, 2026, from 6:25 a.m. to 12:45 p.m. - M-G worked on February 3, 2026, from 6:55 a.m. to 12:10 p.m. - ULP-I worked on February 1, 2026, from 10:37 p.m. to 7:00 a.m. On February 4, 2026, at 12:24 p.m., human resources (HR)-J stated when the licensee opened the facility, they had to wait until they received their license number to open an account for the HFID# 40984 in NetStudy 2.0 which occurred in November. HR-J stated the licensee employed staff from the licensee's parent company and hired new employees for the assisted living (AL) prior to the facility opening. HR-J stated due to hiring people prior to receiving the license number to open a new NetStudy 2.0 account, DHS told them it would be ok to use the parent company license number to onboard people. HR-J stated they affiliated the employees during the survey. HR-J stated it was not done sooner due to "timing". HR-J stated they believed the parent company would still be alerted if ULP-F or M-G was disqualified because they had a background study completed in the old DHS system. HR-J stated they believed they would still receive a letter from DHS if those individuals became disqualified. HR-J stated they were not aware the previously conducted background checks were no longer valid. HR-J stated ULP-I was hired with 22 other ULP and they believed fingerprinting was missed to complete the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01290	Continued From page 8 background study. HR-J stated they noticed the error and corrected it during the survey. The licensee's undated Background Checks policy, indicated all employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01330	Continued From page 9 Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on October 2, 2025, to provide assisted living services. On February 3, 2026, from 7:56 a.m. to 8:25 a.m., the surveyor observed ULP-E answer multiple call lights. ULP-E's record lacked the following required training and/or competency evaluations: - training: - hearing aid. - competency evaluation: - hearing aid; - standby assistance techniques and how to perform them; and - safe transfer techniques and ambulation. On February 5, 2026, at 3:59 p.m., via email, clinical nurse supervisor (CNS)-C wrote hearing aid training/competency evaluation, and competency evaluations for transfers and ambulation have been assigned for ULP-E to	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01330	Continued From page 10 complete. This indicated the licensee had not completed the required training and competencies listed above with ULP-E. The licensee's undated Personnel Records policy indicated personnel files would include a record of all required training for unlicensed personnel and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01440	Continued From page 11 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired to the parent company of the licensee on August 14, 2023, to provide assisted living services and began working for the licensee on October 14, 2025, when the first resident was admitted. ULP-B's personnel file included a medication administration competency completed on October 10, 2025. ULP-B's record lacked a 30-day supervision for medication administration. On February 3, 2026, at 7:47 a.m., the surveyor observed ULP-B administer medication to R1. On February 3, 2026, at 8:43 a.m., the surveyor requested ULP-B's full employee record.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01440	Continued From page 12 On February 3, 2026, at 11:19 a.m. and 2:32 p.m., via email, the surveyor requested ULP-B's 30-day supervision for medication administration in addition to the verbal requests made. On February 3, 2026, at 11:41 a.m., ULP-B stated they received several hours of medication training from the nurse on medication administration. ULP-B stated prior to passing medication independently, they met with management and the nurse to decide if they were ready to pass medication independently. The surveyor inquired if they received 30-day supervision after they started to pass medication. ULP-B stated, "I can't remember I may have but I do not remember." On February 3, 2026, at 1:56 p.m., the surveyor verbally requested ULP-B's 30-day supervision. Clinical nurse supervisor (CNS)-C stated the nurses conducted 30-day supervisions on medication administration and they would find the document. On February 5, 2026, at 9:25 a.m., the surveyor verbally requested ULP-B's 30-day supervision. After multiple attempts to obtain ULP-B's documentation on 30-day supervision, the surveyor did not receive any documentation prior to February 5, 2026, at 4:00 p.m. The licensee's undated Personnel Records policy indicated the personnel record would include results of supervision observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 13	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 14 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to accurately assess a resident who required assistance to apply and remove a prosthetic limb for one of three residents reviewed (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on October 15, 2025, and began receiving assisted living services. R1's diagnoses included depression, Parkinsons disease, restless leg syndrome, insomnia, muscle weakness, and repeated falls.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 15 R1's service plan signed on January 26, 2026, indicated R1 received assistance with wheelchair mobility, ambulation, housekeeping, vital sign monitoring, laundry, toileting, bathing, cueing for grooming, meals, and dressing. The service plan indicated in the event of an evacuation R1 would need their prosthesis, walker, and wheelchair. In addition, R1 could dress, undress, and select clothing with physical assistance. R1's ongoing assessment titled LCS Health and Services Evaluation - (HSE) (MN) -V2 dated December 30, 2025, indicated R1 had a left below the knee amputation and used a prosthesis to assist with mobility and ambulation. In addition, the assessment indicated R1 needed minimal assistance for dressing. R1 could dress, undress, and select clothing but may need to be reminded and supervised. The assessment did not address whether R1 required assistance with application, removal, or monitoring of skin integrity related to the prosthetic limb. R1's Therapy note dated January 27, 2026, indicated R1 was still able to apply their left lower extremity prosthetic however, R1 was having difficulty applying clothing over prosthesis and was fearful of falling. R1's Therapy note dated February 4, 2026, written during the survey, indicated education was provided to R1 and staff on how to apply and remove the prosthetic device. R1 was able to demonstrate application, removal, and cleaning of the device. R1 needed occasional assistance with pulling up the strap to seal the prosthesis onto their stump. Information was provided to nursing to assist with training.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 16 On February 3, 2026, at 8:25 a.m., ULP-E stated they occasionally assisted R1 with the prosthetic limb. On February 4, 2026, at 9:48 a.m., R1 stated staff had assisted with the application of their prosthetic limb for the last couple of weeks because the application of the limb was getting harder and took them over half an hour to apply. R1 stated they received assistance on February 4, 2026, with application of the prosthetic limb. On February 4, 2026, at 11:43 a.m., clinical nurse supervisor (CNS)-C stated R1 preferred to apply their prosthetic limb independently. CNS-C stated they held a care conference last week and family asked staff to check on R1 to make sure they were "ok" applying and removing their prosthetic limb. CNS-C stated family requested staff support R1 with their prosthetic device. CNS-C stated after the care conference they had therapy evaluate R1 to make sure R1 was still able to apply their prosthetic limb. CNS-C stated staff assisted with the prosthetic limb if R1 needed assistance, but the licensee did not charge R1 for the assistance. CNS-C stated staff offered to assist R1 with their prosthetic limb because it was taking over 30 minutes for R1 to apply it independently. CNS-C stated R1 accepted assistance from staff most of the time if they had an activity they wanted to attend. CNS-C stated staff check R1's skin under the prosthetic limb The surveyor inquired where staff documented assisting R1 with the limb. CNS-C stated it was documented under dressing. The surveyor inquired if staff were trained to assist with prosthetic limb application and removal. CNS-C stated the licensee would assign training in Relias (a training software), and ULP would be trained in general prosthetic devices as other sections of	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 17 the facility (different licensee's) had prosthetic devices, and they were currently completing staff training on prosthetic limbs. CNS-C stated ULP had not yet completed competency evaluations on prosthetics however, if there was a need, therapy became involved and complete training and evaluations for ULP. CNS-C stated R1 had asked for assistance with the prosthetic limb for the past month. The surveyor inquired why the prosthetic was not addressed on the assessment. CNS-C stated the family did not want staff to "do it" but they did want staff to support the prosthetic. On February 5, 2026, at 11:34 a.m., CNS-C said therapy said R1 was "ok" to apply their prosthetic limb however, staff needed to prompt them. CNS-C stated R1 liked to be independent with limb application. In contradiction to the interview on February 4, 2026, at 11:43 a.m., CNS-C then stated they did not know staff were applying the prosthetic device. On February 5, 2026, at 8:58 a.m., CNS-C provided the surveyor with multiple documents and stated the licensee would put them into effect for ULP. The documents were as follows: - Care of a Prosthetic, a competency evaluation for a prosthetic; and - [R1] Prosthetic, detailed instructions on how to apply R1 prosthetic. The licensee's Assessment/Service Plan/Health and Service Evaluation policy dated October 13, 2025, indicated a RN or designee would complete the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs. The assessments would be completed periodically but no less than every 90 days and with changes in the resident's condition.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01620	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have an accurate service plan that included all services to be provided for two of three residents (R1, R8).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01640	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on October 15, 2025, and began receiving assisted living services. R1's diagnoses included depression, Parkinsons disease, restless leg syndrome, insomnia, muscle weakness, and repeated falls. On February 3, 2026, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-B administer two tablets of carbidopa levodopa extended release 25 milligrams (mg) - 100 mg, apixaban 2.5 mg, lisinopril 15 mg, and sotalol 80 mg to R1. R1's service plan signed on January 26, 2026, indicated R1 received assistance with wheelchair mobility, ambulation, housekeeping, vital sign monitoring, laundry, toileting, bathing, cueing for grooming, meals, and dressing. R1's service plan lacked information related to R1's medication administration. R8 R8 was admitted to the licensee on November 20, 2025, and began receiving assisted living	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01640	Continued From page 20 services. R8's diagnoses included syncope, shortness of breath, heart failure, atrial flutter, hypertension, and megloblastic anemia (larger than normal red blood cells). R8's ongoing assessment titled LCS Health and Services Evaluation - (HSE (MN) - V2 dated January 21, 2026, indicated R8 received medication administration and R8 used the community preferred pharmacy. R8's Service Plan Report signed January 12, 2026, indicated R8 needed assistance with oxygen equipment, hearing aid placement, vital sign monitoring, laundry, housekeeping, shopping, and respiratory care. R8's service plan lacked information related to R8's medication administration. On February 2, 2026, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-C stated the service plan was created based on the resident assessment and showed the services the residents would receive from the licensee. CNS-C stated the service plan was updated when revisions were made based on the resident assessment, and all revisions would require a signature by the resident or the resident's family. The licensee's undated Contents of Service Plans policy indicated the service plan would include a description of the services provided. In addition, the service plans were reviewed and revised as needed based upon ongoing resident assessments. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01640	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01650	Continued From page 22 all required content for three of three residents (R1, R2, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2025, and began receiving assisted living services. R1's diagnoses included depression, Parkinsons disease, restless leg syndrome, insomnia, muscle weakness, and repeated falls. R1's service plan signed on January 26, 2026, indicated R1 received assistance with wheelchair mobility, ambulation, housekeeping, vital sign monitoring, laundry, toileting, bathing, cueing for grooming, meals, and dressing. R2 R2 was admitted to the licensee on October 20, 2025, and began receiving assisted living services. R2's diagnoses included pulmonary fibrosis, acute respiratory failure with hypoxia, and cognitive communication deficit. R2's Service Plan Report signed January 16,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01650	Continued From page 23 2026, indicated R2 received assistance with respiratory care, wound care, socialization, escorts, transfers, bathing, vital sign monitoring, housekeeping, laundry, shopping, medication administration, grooming, meals, and dressing. R8 R8 was admitted to the licensee on November 20, 2025, and began receiving assisted living services. R8's diagnoses included syncope, shortness of breath, heart failure, atrial flutter, hypertension, and megloblastic anemia (larger than normal red blood cells). R8's Service Plan Report signed January 12, 2026, indicated R8 needed assistance with oxygen equipment, hearing aid placement, vital sign monitoring, laundry, housekeeping, shopping, and respiratory care. R1, R2, and R8's service plans lacked the following content: - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On February 5, 2026, at 10:11 a.m., the surveyor inquired where they would find in the service plan the methods and monitoring of assessment and staff providing services. Clinical nurse supervisor (CNS)-C stated they scheduled the assessments under the evaluations system in PointClickCare (a documenting software). Registered nurse (RN)-A stated they print out each assessment and provide the assessment to the residents at their care conferences. CNS-C then called regional of clinical services (RCS)-O via speaker	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01650	Continued From page 24 phone to ask where they could locate the information listed above. RCS-O stated they would look into where it was located because they were unable to provide an answer and would contact the surveyor. The surveyor did not hear back from RCS-O prior to the completion of the survey. On February 5, 2025, at 11:24 a.m., CNS-C provided the surveyor with a contract and stated it was where the schedule and monitoring of assessments was located. The surveyor observed the licensee's undated blank Assisted Living Residency Agreement Direct Admit contract included a section titled 3.1 Medical Assessment which read, "Prior to execution of this contract, or occupancy of the Assisted Living Residence, whichever is earlier, a medical assessment will be conducted by a primary physician or a registered nurse. A reassessment will be conducted no more than 14 days after the initiation of services. The purpose of the medical assessment is to determine whether we can provide the level of care you require and forms the basis for the development of a service plan." Although the contract discussed the initial two assessments, it did not discuss further assessments that would occur at the facility and did not indicate how the assessments would be conducted. The licensee's undated Contents of Service Plan policy indicated the service plan would include the schedule and methods of monitoring assessments and schedule and methods of monitoring staff providing services. No further information was provided.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01650	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01730	Continued From page 26 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2025, and began receiving assisted living services. R1's diagnoses included depression, Parkinsons disease, restless leg syndrome, insomnia, muscle weakness, and repeated falls.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01730	Continued From page 27 R1's service plan signed on January 26, 2026, indicated R1 received assistance with wheelchair mobility, ambulation, housekeeping, vital sign monitoring, laundry, toileting, bathing, cueing for grooming, meals, and dressing. R1's service plan lacked information related to medication administration. On February 3, 2026, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-B administer two tablets of carbidopa levodopa extended release 25 milligrams (mg) - 100 mg, apixaban 2.5 mg, lisinopril 15 mg, and sotalol 80 mg to R1. R1's LCS HSE Addendum (MN)- V1 ongoing assessment dated February 4, 2026, indicated where R1's medications were stored. R1's ongoing assessment titled LCS Health and Services Evaluation - (HSE) (MN) - V2 dated December 31, 2025, indicated R1 received medication administration and R1 used the community preferred pharmacy. R2 R2 was admitted to the licensee on October 20, 2025, and began receiving assisted living services. R2's diagnoses included pulmonary fibrosis, acute respiratory failure with hypoxia, and cognitive communication deficit. R2's Service Plan Report signed January 16, 2026, indicated R2 received assistance with respiratory care, wound care, socialization, escorts, transfers, bathing, vital sign monitoring, housekeeping, laundry, shopping, grooming, meals, dressing, and required daily assistance or	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01730	Continued From page 28 cueing to take medication and treatments. R2's assessment titled LCS Health and Services Evaluation -(HSE) (MN)-V1 dated November 3, 2025, indicated R2 received medication administration and R2 used the community preferred pharmacy. R2's assessment tilted LCS HSE Addendum (MN)-V1 dated January 1, 2026, included where R2's medications were stored. R8 R8 was admitted to the licensee on November 20, 2025, and began receiving assisted living services. R8's diagnoses included syncope, shortness of breath, heart failure, atrial flutter, hypertension, and megloblastic anemia (larger than normal red blood cells). R8's Service Plan Report signed January 12, 2026, indicated R8 needed assistance with oxygen equipment, hearing aid placement, vital sign monitoring, laundry, housekeeping, shopping, and respiratory care. R8's service plan lacked information related to medication management. R8's ongoing assessment titled LCS Health and Services Evaluation - (HSE) (MN) - V2 dated January 21, 2026, indicated R8 received medication administration, and R8 used the community preferred pharmacy. R8's assessment tilted LCS HSE Addendum (MN)-V1dated January 21, 2026, indicated where R8's medications were stored.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01730	Continued From page 29 R1, R2, and R8's electronic medication administration records (EMAR) included tasks assigned to specific team members. R1, R2, and R8's medication management plans comprised of multiple documents lacked the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On January 5, 2026, at 10:42 a.m., the surveyor sat down with clinical nurse supervisor (CNS)-C with their computer and requested them to show the surveyor the two pieces of the medication management plan that the surveyor was unable to locate. CNS-C stated the prescriber, or the nurse would send in orders to the pharmacy. The surveyor requested CNS-C to show the surveyor the information. CNS-C stated they have a spot to fill in for E-Fills on the computer. The surveyor requested again to see where they had written who would be responsible for medication refills for the residents. CNS-C stated they needed to get another nurse to assist with the question. CNS-C left the room to get registered nurse (RN)-A. The surveyor then requested they show the surveyor who was responsible for monitoring medication refills and written information on when an ULP should contact a nurse if problems arouse with medication management. CNS-C stated their systems kept a count of how many medications were remaining, and the system would send for a refill when needed. CNS-C was unable to show the surveyor written	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01730	Continued From page 30 documentation and continued to verbally describe the licensee's process for medication refills. CNS-C then stated they did not have anything related to when staff should contact the nurse because they had a nurse 24 hours in the facility and they were always available to assist. CNS-C stated the licensee used the same assessment for all residents who resided in the facility for the medication management plan. In addition to verbal requests, the surveyor requested the medication management plan policy from the licensee on February 5, 2026, at 11:33 a.m., via email. The surveyor received other policies related to medication administration, however, did not receive a policy that addressed the medication management plan content prior to the conclusion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medications according to the manufacturer's directions for two of two residents (R4, R5) who had refrigerated medications.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01880	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 2, 2026, at approximately 10:41 a.m., during a facility tour, the surveyor observed the licensee's secured medication refrigerator and observed the refrigerator temperature at 48 degrees Fahrenheit (F). The surveyor also observed a medication refrigerator log with the months January, February, and March written across the top row and columns for a staff member to initial. The surveyor observed no temperatures recorded. In addition, the surveyor observed the following medication in the medication refrigerator: - time sensitive medication from a different licensee connected to the building; - R4 three bottles of latanoprost 0.005 percent (%); and - R5 five bottles of Rhopressa 0.02 %. On February 5, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-C stated nurses monitored the medication refrigerator temperatures daily and the temperature log was kept on the medication refrigerator. The surveyor explained what they observed on the medication refrigerator temperature log. CNS-C stated they believed it was hung on from February 1, 2026, and the form was old. CNS-C stated they believed that was	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01880	Continued From page 32 why the months were crossed off and written in on the temperature log. CNS-C stated they might have a previous temperature log to provide. The surveyor requested to see the previous temperature log. On February 5, 2026, at 12:40 p.m., CNS-C inquired if the surveyor received the medication refrigerator temperature log from the previous month. The surveyor stated they did not receive any additional medication refrigerator logs. The surveyor explained that the temperature was still out of range and they did not document for the first day of February even if they were to provide the new log however, the surveyor would accept the log to place into the record. CNS-C stated they would provide the surveyor with the additional logs they stated they found. The surveyor did not receive any additional temperature logs from the licensee by 4:00 p.m., upon completion of the survey. The manufacturer's instructions for latanoprost ophthalmic solution 0.005 % dated August 2011 indicated unopened bottles of latanoprost should be stored under refrigeration at 36 degrees F through 46 degrees F. The manufacturer's instructions for Rhopressa 0.02 % indicated an unopened bottle of Rhopressa should be stored at 36 degrees F to 46 degrees F until opened. The licensee's undated Storage of Medications policy indicated when secured storage of medications was necessary, the registered nurse or licensed practical nurse would identify where the medications would be stored, how they will be secured or locked under proper temperature controls, and who has access to the medications.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01880	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label time sensitive medication with the date when opened for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 2, 2026, at 10:41 a.m., during a facility tour, the surveyor observed the licensee's medication cart and observed an opened latanoprost ophthalmic eye solution 0.005 percent	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01890	Continued From page 34 (%) not labeled with the date opened for R4. On February 5, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-C stated time sensitive medication should be labeled with the date they were opened. The manufacturer's instructions for latanoprost ophthalmic solution 0.005 % dated August 2011 indicated once a bottle of latanoprost was opened it may be stored at room temperature for six weeks and then discarded. The licensee's undated Storage of Medications policy indicated until the medication is set up for immediate or later administration by a nurse a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number name of drug, strength and quantity of drug, expiration date of time-dated drug, direction for use, resident name, prescriber name, date of issue, and the name and address of the licensed pharmacy that issued the medications. The policy did not address dating time sensitive medications once opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01960	Continued From page 35 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments administered for one of two residents (R2) who received oxygen and failed to administer treatments as ordered for one of two residents (R8) who received oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: DOCUMENTATION R2 was admitted to the licensee on October 20, 2025, and began receiving assisted living services. R2's diagnoses included pulmonary fibrosis, acute respiratory failure with hypoxia, and cognitive communication deficit. R2's Service Plan Report signed January 16, 2026, indicated R2 received assistance with	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01960	Continued From page 36 respiratory care, wound care, socialization, escorts, transfers, bathing, vital sign monitoring, housekeeping, laundry, shopping, medication administration, grooming, meals, and dressing. R2's prescriber order dated January 16, 2026, included give 1 through 4 liters (L) of oxygen as needed (PRN). R2's prescriber order dated February 4, 2026, written during the survey, included give oxygen at 2 L via nasal canula PRN for breathing comfort. R2 able to determine when oxygen would be beneficial. R2's Treatment Administration Record (TAR) dated January 1, 2026, through January 31, 2026, included give 1 L of oxygen PRN from January 1 to January 16, 2026, and give 1L through 4 L of oxygen PRN from January 16 through January 31, 2026. The TAR indicated R2 did not receive oxygen in the month of January. R2's TAR dated February 1, 2026, through February 28, 2026, included give 1L through 4 L of oxygen PRN. The TAR indicated R2 did not receive oxygen in the month of February. On February 3, 2026, at 8:05 a.m., the surveyor observed R2 on 2 L of oxygen via nasal cannula. On February 4, 2026, at 9:58 a.m., R2 stated they used oxygen daily at the facility. On February 4, 2026, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-C stated only nurses had access to the TAR (record review revealed ULP were documenting on the TAR). CNS-C stated R2 used oxygen PRN and if R2 used oxygen it would be indicated on the TAR. The surveyor showed CNS-C the lack of	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01960	Continued From page 37 documentation on the TAR and asked why oxygen use had not been documented. CNS-C stated they would look into it and report back to the surveyor. On February 5, 2026, at 8:09 a.m., ULP-H stated R2 used their oxygen when they were short of breath, and R2 used their oxygen prior to breakfast before they went down to the dining room. On February 5, 2026, at 9:21 a.m., ULP-I stated they normally worked overnight, and R2 used oxygen during their shifts. On February 5, 2026, at 9:33 a.m., ULP-K stated R2 received 2L of oxygen for comfort and R2 has worn oxygen during their shifts. ULP-K stated the nurses documented R2's use of oxygen. On February 5, 2026, at 10:42 a.m., the surveyor sat down with CNS-C and registered nurse (RN)-A with their computer and requested them to show the surveyor where they documented usage of oxygen for R2. RN-A showed the surveyor the TAR for February which included a new order written on February 4, 2026, and entered as active into the TAR on February 5, 2026. The surveyor clarified the request to CNS-C and RN-A. CNS-C and RN-A continued to show the surveyor different sections of the medical chart that addressed oxygen but did not address documentation to record if R2's oxygen had been administered. CNS-C and RN-A were unable to show the surveyor documentation of oxygen administration. TREATMENT ERROR R8 was admitted to the licensee on November 20, 2025, and began receiving assisted living	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01960	Continued From page 38 services. R8's diagnoses included syncope, shortness of breath, heart failure, atrial flutter, hypertension, and megloblastic anemia (larger than normal red blood cells). R8's Service Plan Report signed January 12, 2026, indicated R8 needed assistance with oxygen equipment, hearing aid placement, vital sign monitoring, laundry, housekeeping, shopping, and respiratory care. The licensee printed an order report on January 27, 2026, titled Order Summary Report which indicated R8 was on 2 L of oxygen via nasal cannula as of December 22, 2025; the order report was unsigned. The next signed order related to oxygen was dated January 4, 2026, in the form of a progress note from R8's provider indicating R8 was dependent on 2.5 L of supplemental oxygen. R8's TAR dated January 1, 2026, through January 31, 2026, included the order of continuous oxygen at 2 L via nasal cannula. The TAR did not reflect a change in the supplemental oxygen order after January 4, 2026. Further, after January 4, 2026, the TAR indicated the following: - staff documented R8 used 2 L of oxygen 48 times during the month; - staff documented R8 used 2.5 L of oxygen 9 times during the month; and - staff documented R8 used 3 L of oxygen on January 3, 2026. On February 5, 2026, at 11:13 a.m., the surveyor inquired why R8 was not consistently receiving oxgen per the provider's order. RN-A stated R8's	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
01960	Continued From page 39 order was changed to 2 L on December 22, 2025, and they would have to look at the orders. The licensee's 6.33 Oxygen policy dated October 10, 2025, read, " if [licensee name] accepts responsibility for the ordering, refilling, and administration of oxygen, then oxygen shall be managed in the same manner as an ordered medication, including requiring a physician order." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R1) who utilized consumer bed rails. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 40 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on October 15, 2025, and began receiving assisted living services. R1's diagnoses included depression, Parkinsons disease, restless leg syndrome, insomnia, muscle weakness, and repeated falls. R1's service plan signed on January 26, 2026, indicated R1 received assistance with wheelchair mobility, ambulation, housekeeping, vital sign monitoring, laundry, toileting, bathing, cueing for grooming, meals, and dressing. In addition, the service plan indicated halo/transfer pole for transfers. R1's Treatment Administration Record dated February 1, 2026, through February 28, 2026, indicated R1 had a right-side bed rail located at the top of their bed for mobility and staff were to perform a safety check every shift. On February 3, 2026, at 8:25 a.m., the surveyor observed a consumer bed rail under R1's mattress. The bed rail did not have an identification sticker on the device. The device was in the shape of two U's, one of the U's connected at the center of the other U shape. The device was easily able to be moved and was not secured to the bed frame. On February 3, 2026, at 8:56 a.m., the surveyor requested information related to R1's bed rail. On February 3, 2026, at 5:15 p.m., the surveyor received an email containing R1's medical record.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 41 R1's most recent AL Bed Safety/Supportive Device Risk Evaluation was dated October 15, 2025, and included the following: - R1 was unable to reposition self independently in bed; - R1 used a one half top side rail; - R1or responsible party requested the desire to have bed rails; - there was a provider's order in place for bed rails; - bed rails were used as an enabler to promote independence and safety; - risk and benefits of bed rail use were discussed with R1 and/or responsible party; and - R1 and/or responsible party consented to bed rails. R1's bed rail assessment lacked the following: - type of bed rail being utilized; - ensure the bed rail was securely attached to the bed frame per manufacturer's instructions. In addition, R1's record lacked information to indicate the licensee reviewed the United States Consumer Product Safety Commission (CSPC) website to see if the bed rail had been recalled. Further, R1's record lacked any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R1's bed rail assessment included under section B. Resident Status/Condition, "Identify Resident factors that impact need for supportive devices with restraining qualities." There was a check box with an answer of "Unable to Reposition Self Independently in Bed." The assessment did not evaluate or consider whether the bed rail had the effect of being an improper restraint. On February 4, 2026, at 9:48 a.m., clinical nurse	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 42 supervisor (CNS)-C stated R1's bed rail did not have an identifying label on it. CNS-C stated last evening they spoke to R1's family about R1's bed rail and the resident and family were adamant about still utilizing the current bed rail. CNS-C stated R1 had previously been offered a different bed rail that the licensee prefers to use. CNS-C stated maintenance performed an entrapment test on R1's bed rail yesterday evening and it passed the requirements. On February 4, 2026, at 10:55 a.m., CNS-C stated the licensee used a standardized assessment, the same as R1's, for bed rails for all residents who had a bed rail. CNS-C stated the standard assessment did not address if the bed rail was attached to the bed frame per manufacturer's instructions. CNS-C stated that when a person has a bed rail, nursing obtains a prescriber order and talks to therapy to see if the resident is appropriate to use the device. CNS-C stated they discuss bedrails as an interdisciplinary team. CNS-C stated they did not have manufacturer's instructions for R1's bed rail however, they believed they did at one point of time but may have lost them. The surveyor inquired if there was no label how they could know what product it was and how it was supposed to be installed. CNS-C stated they picked a consumer bed rail that looked similar. The surveyor asked CNS-C if they checked the CPSC website for recalls. CNS-C said they checked for the other bed rail devices they have in their facility, as other residents used a Halo brand device however, they did not check if R1's device had been recalled. When the surveyor requested CNS-C demonstrate where the licensee document's they check for recalls, CNS-C was unable to do so.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 43 On February 4, 2026, at 2:46 p.m., the surveyor observed the CPSC website. The surveyor observed a bed rail that looked like R1's bed rail which was recalled March 9, 2023. On February 4, 2026, at 2:55 p.m., CNS-C confirmed R1's bed rail looked like the product on the CPSC website. The FDA document titled A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts dated December 11, 2017, read, "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." In addition, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 13, 2025, read, "Unlike hospital beds, there is no current published guidance related to portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FAQ also indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 44 must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, it included, " Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's undated Devices and Device Assessment or Side Rails policy, indicated physical device assessment would be conducted every 90 days or with significant change to determine if the device was still needed to enhance resident safety. In addition, to the assessment, two times per year, the CNS or designee would check CPSC for recalled bed rails. If a licensed nurse or other designee believed that the assistive device places the resident at risk for harm it would be removed, and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40984	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM WOODS ASSISTED LIVING	5867 CHESHIRE PARKWAY N PLYMOUTH, MN 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) COMPLETE DATE
02310	Continued From page 45 the family would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Trillium Woods Assisted Living
5867 Cheshire Parkway N
Plymouth, MN 55446
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40984

Risk:
License:
Expires on:
CFPM: MORGAN MARIE BELGARDE
CFPM #: FM61165; Exp: 08/17/2028

Inspection Info

Report Number: F8087261012
Inspection Type: Follow-up - Single
Date: 2/3/2026 Time: 12:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH FOOD AND BEVERAGE DIRECTOR MORGAN BELGARDE.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND HRD NURSE SURVEYOR.

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

I acknowledge receipt of the Metro District Office inspection report number F8087261012 from 2/3/2026

John Boettcher

MORGAN BELGARDE
FOOD AND BEVERAGE DIRECTOR

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Trillium Woods Assisted Living
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087261012
Inspection Type: Follow-up
Date: 2/3/2026
Time: 12:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 37 Degrees F.
Comment: SMALL
Violation Issued?: No

Food Temperature: Product/Item/Unit: LIQUID EGG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment: SMALL
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 2 Degrees F.
Comment: FRY
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 35 Degrees F.
Comment: LARGE
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment: LARGE
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment: LARGE
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Under Counter Freezer at -2 Degrees F.
Comment: ICE CREAM
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 37 Degrees F.
Comment: SIDE KITCHEN
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment: SIDE KITCHEN
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 0 Degrees F.
Comment: SIDE KITCHEN
Violation Issued?: No