Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204131581M
Compliance #: HL204136182C

Date Concluded: May 6, 206

Name, Address, and County of Licensee Investigated:
Trinity Terrace
3330 213th Street West
Farmington, MN 55024
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation: The facility neglected the resident when it failed to ensure the outside sidewalk area was safe when the resident fell on the ice and fractured her elbow.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The main sidewalk area was clear per the resident and witness. The resident stepped onto a patch of ice at the curb because the car she was going to get into pulled up too far past the main walk area.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed walkway and high traffic areas outside the facility.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and atrial fibrillation with a pacemaker. The resident's service plan included assistance with

pendant checks, promoting safety awareness, standby assistance with bathing, applying and removing lymphedema sleeves and foot soaks. The resident's assessment indicated she is independent with mobility and used a four wheeled walker for distances.

A concern arose when the facility director heard the resident yelling for help outside the building. The director found the resident on the ground and called 911 for assistance. The resident had hit her head and was bleeding but declined ambulance transport. The resident reported she had stepped outside for a coffee outing, slipped on the ice near the curb, and fell. The resident went to the hospital by private vehicle.

The emergency room discharge note indicated the resident was seen for fracture of the left radius (elbow area), closed head injury which was negative for internal bleeding, hematoma (bruise) and abrasion (scrape to the skin). The resident was advised to wear an arm sling and take acetaminophen (pain reliever) for pain.

The investigation included a review of the facility's fall incidents. No other falls outside due to similar circumstances.

During an interview, the director stated the areas had been previously salted. She said the main sidewalk was clear but off to the side there was ice that may have formed from melting off the roof overhang that puddled and refroze overnight.

During interview, a maintenance staff member stated it is all staff responsibility to ensure the walkways are clear with a salt bucket and shovels kept in the entrance area to use when needed. The facility contracts with an outside company for snow removal and ice treatment in the parking lot areas.

When interviewed by the investigator, the resident stated her friend who picks her up for coffee pulled up into the drive area and stopped too far ahead. The back end of the car lined up with the walkway, so the resident stepped off to the side a little and it happened to be on a patch of ice. The resident said she fell, hit the back of her head and fractured her elbow. She stated the walkway itself was clear of ice. The resident said she has gone out for coffee weekly and out for appointments and never had any other problems with sidewalk condition.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The icy area was salted after the fall. Management increased awareness and sent out extra reminders with all staff to check all outdoor walk areas throughout the day and night.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20413	A. BUILDING: _____ B. WING _____	C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINTY TERRACE	3330 213TH STREET WEST FARMINGTON, MN 55024

(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 On April 9, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL204136182C/#HL204131581M. No correction orders are issued.	0 000		