

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204133486M
Compliance #: HL204132882C

Date Concluded: September 29, 2026

Name, Address, and County of Licensee

Investigated:

Trinity Terrace Assisted Living
3330 213th ST W
Farmington, MN 55024
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN,
BSN, 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(s):

The facility neglected the resident when the facility failed to assist the resident with wound care and bathing, which resulted in the resident being hospitalized.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident did not receive a shower for approximately three weeks, occupational therapy was working on shower transfers with the resident prior to the resident being transferred to the hospital. In addition, in the days leading up to the resident's hospitalization, facility staff and occupational therapy did not recall seeing any wounds to the resident's bilateral legs. Following the resident's hospitalization, the resident was transferred to a higher level of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted occupational therapist. The investigation included review of the resident records, hospital records, staff schedules, and

related facility policy and procedures. Also, the investigator toured the facility and observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personality disorder, type two diabetes, anxiety and depression. The resident's service plan included assistance with medication management, and bathing. The resident's assessment indicated the resident had cognitive impairment but was independent with skin care, transfers, walking, and toileting and had no open wounds. The resident's assessment indicated the resident required assistance with bathing and dressing.

The resident's medical record indicated over the course of three weeks the resident developed a fear of showering because she could not get lift her leg over a ledge to get into the shower. An occupational therapist and facility staff attempted to work with the resident regarding shower transfers and the resident refused. The medical record indicated the resident had no skin breakdown, no redness or open areas. The resident was capable of completing the shower task, however, continued to refuse and stated she could not lift her leg high enough to get over the ledge of the shower. Facility leadership notified the resident's family member and primary care provider that there were concerns that the resident would develop a urinary tract infection and skin breakdown because of the resident refusing to shower. The resident's medical record indicated the resident was assessed to have increased confusion, unable to hold a conversation, was incontinent of bowel and bladder and had closed blisters to her lower legs. The resident was transported to the hospital.

The hospital record indicated the resident had a urinary tract infection and had developed cellulitis (a common bacterial infection that affects the deeper layers of the skin and the tissues underneath) to both legs. The resident indicated she did not have facility staff look at her legs. In addition, the hospital record indicated the resident's wounds were suspected to be related to a traumatic etiology (caused by a sudden, external, physical event or force rather than an internal disease process). The hospital record indicated the resident's leg wounds were from hitting her legs on the wheelchair when she was sitting in a recliner. The hospital record indicated the resident was treated with antibiotics and transferred to a higher level of care.

During an interview, unlicensed staff member #1 stated the resident use to do complete activities of daily living such as transfer herself, toilet herself and would shower with staff assistance. But then, towards the final weeks at the facility before being hospitalized, the resident refused services. Attempts were made to assist the resident with showers and cares. In the bathroom, there was a grab bar, and a shower chair, but the resident could not get over the ledge of the shower to get into the shower. The resident refused to let staff assist with hygiene, the resident stated she would wash herself up in the bathroom. Unlicensed staff member #1 stated the resident refused to let staff look at her skin, and often had her legs covered under a blanket.

During an interview, unlicensed staff member #2 stated in the final weeks prior to the resident being hospitalized, the resident was very adamant about not wanting to take a shower. Unlicensed staff member #2 stated the resident liked to have lotion applied to her legs but then the resident always kept a blanket over her legs and would not elevate her legs in her recliner.

During an interview, facility leadership stated the resident was scheduled for two showers a week, and in the weeks leading up to the resident's hospitalization, the resident would refuse showers. Facility leadership and unlicensed staff would try to encourage the resident to take a shower, but the resident had developed a fear and became scared of showering. Facility leadership stated a referral was made to occupational therapy for shower assistance. When the resident was sent to the hospital because of increased confusion, the resident's legs were observed to have scabbed over blisters. Facility leadership stated when the resident was sent to the hospital, it was the first time she had seen the blisters on the resident's legs.

During an interview, an occupational therapist stated the resident was initially started on services for cognitive testing, but then the resident developed anxiety and fear of showering. The occupational therapist stated leg exercise were initiated for the resident to increase endurance and strength. The resident had leg weakness but was able to stand for one minute, but the resident would not attempt a shower and would not attempt to step onto the ledge of the shower that was four or five inches tall. The resident's shower had a grab bar and a shower chair, however the resident would become anxious and panic breathing and would refuse to shower. The occupational therapist stated approximately eight days prior to the resident being hospitalized, the resident did not have any open areas or wounds on her legs.

During an interview, a family member stated the resident would refuse services if she felt scared and would try to get the facility staff to do the service the following day.

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: No. Multiple attempts made but could not be reached.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

When the resident had a change in condition, the resident was sent to the hospital for an evaluation.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/17/2026
NAME OF PROVIDER OR SUPPLIER TRINTY TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 August 17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL204133486M / #HL204132882C. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE