

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL215744502M  
**Compliance #:** HL215749068C

**Date Concluded:** July 18, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

TFF Care LLC  
4200 40<sup>th</sup> Avenue North  
Robbinsdale, MN 55422  
Hennepin County

**Facility Type:** Assisted Living Facility with  
Dementia Care (ALFDC)

### **Evaluator's Name:**

Maerin Renee, RN, Special Investigator

**Finding:** Inconclusive

### **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 alleged perpetrator (AP) physically abused the resident when the AP slapped the resident on the arm.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was inconclusive. The AP was providing cares to the resident. Another staff member said she heard yelling and crying from the resident's room. The staff member entered the room, saw the AP yelling at the resident, saw the resident crying, and witnessed the AP punch the resident three times in the arm. However, the AP denied punching or hitting the resident, and the resident was unable to recall the incident due to her cognitive status. Staff assessed the resident, and she had no redness, marks, or injuries.

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

facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services assistance with activities of daily living, meals, laundry, housekeeping, and medication management. The resident's assessment indicated the resident experienced disorientation, and her decision-making was severely impaired.

The facility's internal investigation indicated a staff member arrived at the memory care unit to help the AP with morning cares. When the staff member finished, she went to let the AP know she was leaving the unit. The staff member said she witnessed the AP yelling and slapping the resident. The staff member reported what she saw to an on-call nurse. The AP was sent home, pending an investigation. Staff assessed the resident and did not find visible injuries or marks. The AP's employment was terminated based on suspicion of abuse of the resident. The AP denied wrongdoing.

The resident's progress notes indicated a staff member witnessed the AP yell at and slap the resident on the arm. The on-call nurse instructed the AP to leave the premises immediately. The resident's family member was informed of the incident. There was no visible injury to the resident, and she did not recall such an incident.

A written statement provided by the staff member indicated she went to the resident's room and witnessed the AP yelling at and slapping the resident in the arm. The resident was crying.

When interviewed, a nurse said staff reported the AP had been aggressive with the resident. A staff member described seeing the AP yelling at and slapping the resident's arm. The AP denied anything like that happened. The resident had no visible injuries on her arm and displayed no signs of pain. The nurse said the AP had been a good employee and was very well-liked. The facility decided to err on the side of caution and terminate the AP's employment.

When interviewed, a staff member said she helped memory care residents get dressed for the morning. After she finished, she went to report off to the AP. When she entered the resident's room the staff member witnessed the resident crying and the AP yelling at her. The staff member said she saw the AP hit the resident three times in the arm with a clenched fist. The staff member left the room and reported what she saw to the nurse on call. The AP was instructed to leave the facility.

When interviewed, the AP denied harming the resident. She believed the report was retaliatory and some staff members were resentful of losing work hours after the AP was hired.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section [609.341](#), between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means: ...

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(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

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**Vulnerable Adult interviewed:** No, unable due to cognition.

**Family/Responsible Party interviewed:** No response to interview requests.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The AP is no longer employed by the facility.

**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:  <b>21574</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/08/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TFF CARE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422</b>
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(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	<p><b>Initial Comments</b></p> <p>On July 8, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL215749068C/#HL215744502M. No correction orders are issued.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_