Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL287761942M
Compliance #: HL287763292C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Trinity Suites
205 11th Street
Farmington, MN 55024
Dakota County

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

Evaluator's Name: James Larson, 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(s):
The facility neglected the resident when staff failed to provide safety checks and implement fall precautions. The resident fell and required hospitalization for advanced care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Prior to the fall, staff completed safety checks according to the resident's assessed needs and plan of care. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, employee training files, and facility policy and procedures. At the time of the onsite visit, the investigator observed care and services provided by staff in the facility and the resident's room where she fell.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included disorientation, weakness, falls, and vertigo (dizziness). The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated the resident had a history of unwitnessed falls with injury, requiring assistance for ambulation as well as impaired cognition with poor decision making and required supervision.

Documentation reviewed indicated that four days after the resident admitted to the facility, she had an unwitnessed fall in her room where she sustained injuries and was treated at a local hospital. The resident returned to the facility later that same day.

One week later, the resident experienced another fall. The resident was seated in a recliner in her apartment, when staff members on duty heard the resident call out for help and found the resident on the floor. The resident sustained another injury including broken bones and cuts requiring emergency treatment and hospitalization. After being discharged from the hospital, the resident did not return to the memory care unit and was instead admitted to another care unit at the facility. The resident eventually passed away from unrelated natural causes.

During an interview, a nurse stated that at the time of admission the resident's care plan included scheduled safety checks. After the first fall occurred, scheduled checks to assist the resident to the restroom were added and both services were increased in frequency.

During investigative interviews, multiple staff members stated that during both incidents involving the resident and unwitnessed falls, the resident was in possession of a call light pendant device but were unsure if she activated it to indicate that staff assistance was needed.

During an interview, a family member stated that the resident fell prior to admission at home and at other health care facilities. The family member stated that the facility made sure she was involved with care planning and recalled the resident commenting to her about being checked on around the clock. The family member had no concerns with the care provided by the facility.

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 (deceased)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility staff provided immediate assistance and notified emergency medical services per facility protocol.

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
	28776	A. BUILDING: _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY SUITES	205 11TH STREET 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 June 12, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL287763292C/#HL287761942M. No correction orders are issued.	0 000		