Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204131440M
Compliance #: HL204135881C

Date Concluded: May 5, 2026

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: Substantiated, individual responsibility

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 alleged perpetrator (AP) sexually abused the resident while providing care.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Although the exact dates of abuse were unclear, the resident's accounts of the alleged incident were consistent during separate interviews. The resident had bruising to her breast, which was consistent with her account of the interactions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted also law enforcement. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed general activities and interactions between staff and residents during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included a mental health condition, fibromyalgia, respiratory failure and diabetes. The resident's service plan included assistance with medication management and administration, standby assist with bathing, housekeeping, and meals. The resident's assessment indicated she was oriented to person, place, time and situation but had short term memory issues. She could communicate and make her needs known. She used a walker for mobility around her apartment and a wheelchair for longer distances.

A concern arose when the resident was visibly distressed one day during morning cares. The resident had a circular bruise on her breast. The resident stated a staff member had been rough with her and had grabbed her breast forcibly. The resident said the staff member, a male, worked the night shift, and identified as the AP. The resident was unclear exactly when the assault had occurred.

The facility internal investigation notes indicated the resident went to the hospital for an examination. Hospital records indicated the resident had a bruise on the left breast with chest wall tenderness on palpation.

The AP's statement to the facility at the time was he was in the resident's room three times the night prior to the reported allegation. First to administer medication, the second because the resident called and asked him to sit with her and third, to adjust the thermostat.

Scheduling records indicated the AP worked mainly the night shift from 10:00 p.m. to 6:00 a.m. in the assisted living and picked up shifts that included hours in the memory care unit.

The resident's electronic medication administration record (eMAR) indicated the resident had scheduled 10:00 p.m. medications. The AP had signed off he had given these medications indicating he provided medications to the resident each night he worked.

During an interview, the resident stated she had developed a friendship with the AP, and he was someone to whom she would talk. Then one night he grabbed at her and kissed her. The resident was hesitant to talk about the details as she said it was a traumatic experience and had already been interviewed multiple times after it happened.

During interview, the director stated she interviewed the resident initially alone and her report was consistent with the interview with police which the director sat in on.

During interview, a family member said the resident was interviewed by doctors, nurses, the facility director and a detective on different days and each time the story was the same. The family member had concerns about the AP's behaviors toward the resident had been going on for some time. She said the resident did spend most of her time alone in her apartment.

During interview with the investigator and with law enforcement, the AP stated the only time he had contact with the resident was to bring her medications. The AP denied any physical or sexual contact with the resident. Information obtained via police interview revealed additional sensitive information which was disclosed by the resident regarding the AP's intimate parts [see definition below].

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.

609.341 DEFINITIONS. Subd. 5.**Intimate parts.** "Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility reviewed vulnerable adult training with all staff. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health: The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Farmington City Attorney
Farmington Police Department

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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HL204131440M/#HL204135881C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #HL204131440M/#HL204135881C, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		