Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205519842M
Compliance #: HL205514440C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
Woodbury Estates
2825 Woodlane Dr
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Deb Schillinger 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 wound care was not provided.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility received orders for treatments, which the facility did not provide and arranged for a home healthcare agency (HHA) to provide those cares. However, a delay occurred in the HHA initiating cares and, when discovered by the facility, appropriate action was taken.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the home health agency. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, and lymphedema. The resident's service plan included assisting with compression stockings to put on in the morning and remove at night. The resident's medical record indicated an order for lymphedema [long term swelling in the legs due to a blockage or damage in the lymphatic system] treatment.

A concern arose when the resident did not receive leg wound care. Additionally, the resident's lymphedema had worsened.

Week #1
The resident's medical record indicated the medical provider ordered lymphedema therapy due to increased edema and "weeping" of the lower legs.

The residents progress notes indicated an order for lymphedema treatment was sent to a HHC agency, which had provided treatment for the resident several months earlier for the same issue. The HHC agency communicated cares would be initiated in four days.

An email indicated coordination of care was completed with the facility's in-house PT provider, and they would monitor for worsening of condition and notify the HHC representative as needed.

Week #3
A review of the resident's medical record indicated the lymphedema treatments had not begun.

During the third week, a transcript of a phone message indicated a facility nurse contacted the HHC to inquire about the status of the ordered lymphedema treatment. Three days later an email indicated the HHC representative called back, explained why care was not started and the facility nurse described her concerns the resident's legs were worsening.

Week #4
During the fourth week, the HHC representative arrived to initiate lymphedema therapy and initiated wound care treatments.

During an interview, the facility nurse stated orders were received for lymphedema treatment from the medical provider. She stated she then contacted the HHC provider and was told a representative would see the resident in four days. Several days later, the nurse placed a follow-up call to the HHC representative as she had not received further orders or guidance with the resident's lymphedema treatment.

During the same interview, the nurse stated three days elapsed after the follow-up call, the HHC representative called back and said lymphedema treatment services could not be started as the resident was receiving services from the in-house therapists. The nurse contacted the medical

provider to get orders to discontinue the in-house therapy and news orders for lymphedema therapy to get the treatments started. The nurse stated she informed the HHC representative the resident's condition was worsening and now had blisters present to both lower legs. The nurse stated the facility did not manage wounds and had minimal access to wound care supplies. She stated the facility did not perform all complex wounds and some wounds must be managed by an outside HHC agency.

During an interview, the HHC representative stated a visit was made to the resident four days after the initial order for lymphedema therapy, but services could not be initiated as the resident was receiving therapy with the in-house therapist. The HHC representative stated upon the initial visit, the resident did not have open wounds, and his leg measurements were not that different from when the lymphedema treatment was provided months earlier, so recommendations were provided to the in-house therapist. The HHC representative stated a note was also left for the nurse. The HHC representative stated the in-house therapist did not offer lymphedema treatments.

During the same interview, the HHC representative stated the nurse had called several days later on a Friday and left a message asking if services were initiated and how often the resident would be seen. The HHC representative stated she returned the call to the facility nurse on the following Monday, where the nurse said the resident's lymphedema had worsened and now has blisters present to his lower legs, but he did not have open skin wounds. The HHC representative stated she contacted the in-house therapist two days later, and the therapist indicated there was no change to the resident's legs and the resident was wearing his leg wraps consistently. The following day, the resident was discharged from the in-house therapy provider.

During the same interview, the HHC representative stated she arrived five days later to initiate lymphedema services and was concerned when the resident's legs were weeping fluid and had open skin and blisters, which she was not aware of, and the facility stated they did not have wound care supplies available. The HHC representative stated it was concerning the wound care had not been provided before her visit.

The facility's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) indicated the facility is only able to provide basic wound care. The same document indicated complex wound care and lymphedema wraps was available under resident's arrangement with a third party.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable the

Action taken by facility: The facility relayed the original order to the home care agency, followed up, then re-initiated the order for lymphedema treatment.

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
	20551	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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 March 3, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL205514440C/#HL205519842M. No correction orders are issued.	0 000		