Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273785642M
Compliance #: HL273783240C

Date Concluded: December 18, 2025

Name, Address, and County of Licensee Investigated:
Inver Grove Heights White Pines II
9058 Buchanan Trail
Inver Grove Heights, MN, 55077
Dakota County

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

Evaluator's Name: Kris Detsch, 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 they failed to provide wound care and hygiene/toileting assistance. As a result, the resident developed advanced pressure wounds and skin rashes. The resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had chronic, non-healing wounds which required complex wound care management. The facility did not have the capabilities of providing these types of wound cares, but they did coordinate wound care management with an outside agency. Although the resident developed a skin rash in her groin, candida (yeast) caused this. The resident received multiple antibiotic medications prior to the rash. (Antibiotics can cause yeast infections/rash). Additionally, the facility regularly communicated with the resident's physician about her wounds and health decline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, wound care agency notes, and related facility policy and procedures. Also, the investigator toured the facility and observed medication management, staffing levels, and documentation systems.

The resident resided in an assisted living memory care unit. The resident's diagnoses included diabetes, heart disease, dementia (memory loss), failure to thrive, vascular disease (problems with circulatory system), and chronic skin ulcers not caused by pressure.

The resident's service plan included assistance with bathing, dressing, grooming, meals, medications, and toileting. The resident's nursing assessment indicated her health declined and she had a "severe" weight loss. The assessment indicated the resident needed help with mobility and was incontinent of bowel and bladder. The resident had urinary tract infections (UTI).

Progress notes indicated approximately one month prior to the allegation, the resident went to the hospital, and they determined she had a UTI and low blood sugar levels. The resident returned to the facility with a new wound to her right hip and ankle. The facility nurse cleansed and covered the wounds. The facility nurse told the resident's physician assistant (PA) about the wounds, and the PA told the facility to have physical and occupational therapists (PT/OT) evaluate the resident. The PA also told the facility to get a skilled nursing service (out of facility agency) to manage the resident's hip and ankle wounds. The facility notified the resident's family because they made all medical decisions for her.

During an interview, a nurse manager said she assessed the resident's wounds when she returned from the hospital and contacted an outside agency to come into the facility and provide the wound care to the resident. The nurse manager said there was a delay in obtaining those services because the resident's family was not in agreement. The nurse manager said the facility was only capable of providing basic wound care and they specified this information in their uniform disclosure of assisted living services and amenities (UDALSA). The nurse manger said she measured and cleansed the resident's wounds during this time.

Medical records indicated the resident's physician (MD) went to the facility to assess her health status shortly after she returned. The MD's records indicated the resident required wound care management beyond the capabilities of the facility. The MD used a portal system (electronic communication system) to communicate with the facility. The MD's communication with the facility indicated the resident's family did not agree to start PT/OT, or skilled nursing services for the resident at this time.

Medical records indicated the resident's family took her to a dermatologist (physician who specializes in skin disorders) approximately two weeks after she returned to the facility. The

dermatologist records indicated the resident had chronic, non-pressure wounds to her right thigh, right ankle, right calf, and right finger. The notes indicated the dermatologist cultured (tested) the wounds for bacteria and the test indicated the wounds were infected. The dermatologist gave the resident an oral antibiotic medication to take three times a day for ten days. The notes indicated the dermatologist also attempted to get a skilled nursing agency to do the resident's wound care at the facility. The dermatologist also wanted the resident to go to a wound care clinic (specialty clinic which manages wounds).

Wound care agency notes indicated they started providing wound care to the resident, at the facility, three days after her dermatology appointment. (This was then seventeen days after the PA gave the initial order).

The resident's health continued to decline and progress notes indicated the resident's family took her to an urgency room (UR) two weeks later. The notes indicated the UR physician prescribed two antibiotic medications and completed an X-ray of the resident's right hip. The notes indicated the UR physician wanted the resident to have a magnetic resonance imaging (MRI) to determine if she had osteomyelitis (bone infection). The UR physician discontinued one of the antibiotic medications three days later but added an additional antibiotic medication. (Overall, the resident took three different antibiotics).

Four days later the resident's PA went to the facility and assessed the resident health status. Medical records indicated the PA completed documentation for the resident to have an MRI.

Electronic communication between the PA, wound care agency, and the facility indicated they worked together to try to get the resident into a wound care clinic, however the resident's family did not want her to go until she completed the MRI. The medical team continued to make efforts for the resident to have more diagnostic evaluations.

Progress notes indicated the resident's health continued to decline and vital sign records indicated she lost approximately twenty-five pounds which was 21.47% of her body weight, during the month these events occurred. The PA discussed hospice care (end of life) with the family, however they made the decision to send the resident to the hospital. (This was approximately six weeks after her initial hospital return.)

Hospital records indicated the resident had a UTI with sepsis (life-threatening) infection caused by candida. The records indicated candida also caused the resident's groin rash. The hospital returned the resident to the facility.

During an interview, a director said the facility was unable to provided advanced wound care and coordinated wound care with an agency who came into the facility. The director said the resident continued to require advanced care and discharged from 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: No. Attempted. Did not respond.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated the resident’s medical care with her medical providers.

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
	27378	A. BUILDING: _____ B. WING _____	C 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 November 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL273783240C/#HL273785642M. No correction orders are issued.	0 000		

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