Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303603466M
Compliance #: HL303602840C

Date Concluded: July 23, 2026

Name, Address, and County of Licensee Investigated:
Cornerstone Residence of Fosston
115 1st St E
Fosston, MN 56542-1335
Polk County

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

Evaluator's Name: Ann Boutwell, 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 the resident had an unexplained open wound/injury to a toe, resulting in an infection and amputation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a chronic condition of a hammer toe (a deformity where a toe bends or curls downward at the middle joint), resulting in a blood blister, then a callus, and eventually into an amputation. The facility assessed the toe and coordinated care with the resident's provider and podiatrist.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and a family member. The investigation included review of the resident record, hospital records, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and right second toe amputation due to deformity and chronic wound. The resident's service plan included assistance with weekly showering, morning and evening cares, and weekly nail and footcare. The resident's assessment indicated resident was disorientated to time and place, could become agitated, walked the unit constantly and required assistance with bathing/showering, dressing, personal hygiene, and toileting.

The resident's record indicated licensed staff were notified that a dime sized scab had fallen off the resident's toe following a whirlpool tub bath. The resident had a podiatry consult appointment four days later.

The medical reports indicated the resident was seen by her medical provider and started on an antibiotic for cellulitis (skin infection) on the second toe of the right foot. The report indicated the second toe overlapped the third toe. The podiatry consultation indicated the resident had a hammertoe of the right foot and a skin ulcer with necrosis of the bone. A second toe amputation was recommended and the toe was removed. The sutures were removed, and the incision was healed.

During interviews, licensed staff stated the resident's provider had monitored the callused area over the span of five months. The resident had refused to see the podiatrist who came to the facility two times.

During an interview, unlicensed staff stated when the resident's toe scab fell off, she notified licensed staff. Even though it was late in the evening, the licensed staff answered right away and provided directions to cover the open area.

During an interview, a family member stated family has been happy with her care at the facility and has no concerns. The family member stated her toe was growing over another toe, and the resident had the condition for a long time. A family member stated the resident had surgery and the wound was healed.

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, unable due to dementia.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility reported the change of condition to the medical provider.

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
	30360	A. BUILDING: _____ B. WING _____	C 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(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 30, 2026, the Minnesota Department of Health initated a complaint HL303603466M/HL303602840C. No correction orders are issued.	0 000		