

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306964405M
Compliance #: HL306968613C

Date Concluded: November 6, 2025

Name, Address, and County of Licensee

Investigated:

Inver Grove Heights White Pine
9056 Buchanan Trail
Inver Grove Heights, MN 55076
Dakota County

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

Evaluator's Name: Holly German, 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 properly care for a wound, resulting in the amputation of a toe.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility was made aware of new wounds to the resident's toes by the resident and responded by completing an assessment, notifying the resident's provider and family, obtaining and starting treatment with wound care per the provider's order.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted a family member. The investigation included review of the resident records, skilled wound care services notes, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's amputation site.

The resident resided in an assisted living facility. The resident's diagnoses included type two diabetes, morbid obesity, bilateral lower leg edema, and vascular dementia. The resident's service plan included assistance with nail care, pain management, and safety checks. The resident's assessment indicated the resident was alert, oriented, and required assist with transfers after the amputation.

The resident's progress notes indicated the resident completed a podiatry visit at the facility. The note indicated the resident had a nail pathology that caused pain in the toes, with hammer toes present. The note indicated there was no pulse to the toes and upper foot noted (indicating poor circulation). There were no wounds noted to the resident's feet or toes.

Approximately one and a half months later, the resident's progress notes indicated the resident presented to the nurse's office with complaints of foot pain. Upon inspection, the nurse noted a toenail coming off, and two pressure wounds located between the resident's big toe and second toe that appeared infected. The note indicated the resident's provider was notified. The provider ordered a podiatry consult and an oral antibiotic for five days. The facility contacted a skilled nursing service who stated they would come to the facility in three days to assess the wound.

The progress notes indicated the resident received skilled nursing services for wound care three times weekly per provider orders, and the resident was seen by podiatry services 12 days after wound care had started.

The following day, the resident's wound assessment indicated the wound on the resident's big toe had healed, and treatment continued for the wound on the second toe.

Two weeks later, the resident's wound assessment indicated the nurse had concerns about the wound not healing and appeared to have digressed. The note indicated the nurse was not able to get ahold of the resident's family.

The next day, the resident's progress notes indicated the facility received new wound treatment orders from the provider.

Two weeks later, the resident's wound assessment indicated the wound continued to worsen, and another antibiotic was started. The note indicated another referral to podiatry was received. The note indicated the resident had been none compliant with keeping the wound dry.

Three days later, the resident's progress notes indicated the resident attended the podiatry appointment and he was directed to go to the emergency room, where the resident was admitted to the hospital with intravenous antibiotics.

Two days later, the resident's progress notes indicated facility staff were updated from hospital staff that the resident's toe was amputated.

One and a half months later, the resident's progress notes indicated the amputation site was completely healed, the resident received medical clearance to bear weight on the foot, and physical therapy services continued.

The resident's wound care visit notes from the skilled nursing company indicated the amputation site was healed approximately three weeks after surgery.

During an interview, registered nurse (RN)-1 stated the resident walked into the nursing office and complained of pain in his foot. RN-1 stated upon inspection; two wounds were noted. RN-1 stated the resident's toes rubbed together causing pressure. RN-1 stated the resident was independent at that time and completed his own showers. RN-1 stated the nurses took pictures of the wounds and sent them to the resident's provider, who ordered for skilled nursing to be initiated for wound care treatment. RN-1 stated the resident's family was updated on the wounds, when the resident's son was his power of attorney. RN-1 stated the resident's power of attorney was transferred to another family member shortly after. RN-1 stated she assessed the resident's wound to be none healing, so she alerted the provider, and the resident went to a podiatry appointment right away.

During an interview, the licensed assisted living director (LALD) stated the facility used skilled nursing companies to take care of the facility resident's wounds. The LALD stated the resident was independent with his needs prior to the amputation of his toe. The LALD stated the skilled nursing company staff always checked in with facility staff prior to seeing a resident, and gave the facility staff updates and report on the residents before leaving the building. The LALD stated facility staff were updated on resident changes via a communication book they used to document changes and updates on residents, as well as shared information with staff during the daily stand-up meeting with staff. The LALD stated the nurses worked very hard to heal the resident's wounds, but the resident was not usually compliant with the recommendations provided to him. The LALD believed the resident's noncompliance contributed to the digression of the resident's wounds.

During an interview, RN-2 stated RN-1 requested and received wound care orders, an antibiotic order, and a podiatry referral on the same day the resident's wound was discovered.

During the onsite visit, the resident stated to the investigator he was not sure if the staff treated him well. The resident stated he did not have any concerns about the care he received at the facility. The resident did not want to discuss anything further with the investigator.

During an interview, a family member stated the resident was compliant with his plan of care and could make his needs known. The family member stated she took over the power of attorney for the resident and was notified by the skilled nursing company of the wound care

they did for the resident. The family member stated a facility nurse called her a month and a half later and notified her they were concerned about the resident's wound, and the resident needed to see podiatry right away. The family member stated she took the resident to see podiatry three days later, where they were advised to go to the emergency room. The family member stated the resident had his toe amputated two days later, and he did not have any complications from the amputation.

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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility reported the wound to the resident's provider who ordered referrals and treatment. The facility monitored the wound and communicated with the skilled nursing wound care agency.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2025
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NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE	STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077
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(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	<p>Initial Comments</p> <p>On October 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306968613C/#HL306964405M. No correction orders are issued.</p>	0 000		

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