Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316758102M
Compliance #: HL316758824C

Date Concluded: January 14, 2026

Name, Address, and County of Licensee Investigated:
Blaine White Pines II LLC
12402 Jamestown St. NE
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 was found to have wounds on her feet resulting in hospitalization and amputation of the resident's right lower extremity.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did get diabetic ulcers and had her right lower extremity amputated, the resident had chronic diabetes and peripheral vascular disease (blood flow reduction in the extremities). The facility coordinated care with the resident's health care providers and sent her to the hospital when her health condition changed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's podiatry provider. The investigation included review of the resident's medical records including hospital records, personnel files, staff schedules and related facility policy and procedures. Also, the investigator

observed the facility physical plant, medication administrations, wound treatment observations, cares provided to the residents and staff interaction.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, type two diabetes, diabetic pressure ulcers and peripheral vascular disease. The resident's service plan included assistance with medication management, dressing, grooming, showers and nail care/filing on shower day. The resident's assessment indicated the resident was orient to person was confused and forgetful. The resident could be resistive to cares.

Medical records indicated an administrative nurse assessed the resident and a peanut to grape-sized wounds on her third and fourth toe and a painful left outer heel wound that was peanut-sized wound with drainage. The resident's left foot second toe had a wound that was peanut-sized, open and dry. The resident's wounds were cleansed, treated and a request was made to the resident's provider, for the resident to have a skilled nursing evaluation of the wounds. The resident started oral antibiotics for the wounds.

Medical records indicated three days later, a facility nurse, called 911 due to the resident's worsening wounds. After paramedics arrived, a resident's family member informed staff not to transport the resident to the hospital at that time. Later that same day, the resident's family observed the resident's wound then transported the resident to the hospital for evaluation of the wounds.

Hospital records indicated the resident had a small wound on right foot that had worsened, causing the resident pain and guarding of the foot. The resident was treated with intravenous antibiotics and had an unsuccessful surgical procedure to open the artery in her right leg. Subsequently the resident had her right leg amputated above the knee.

Review of medical records indicated in the weeks prior to the incident, staff documented daily dressing cares for the resident in the morning and evening, along with showers twice per week had been completed. Medical records indicated the resident had a history of diabetic ulcers and peripheral vascular disease but did not have any open areas at the last podiatry appointment.

During an interview, an unlicensed personnel stated when she would give showers she would provide a bed bath because the resident would refuse her showers. The unlicensed personnel stated the resident would get impatient during the bed bath and occasionally she would refuse the bed bath too. An unlicensed personnel stated when she saw concerns with the resident's feet the nurse was notified.

During an interview, a facility staff nurse did not recall any wounds found on the resident prior to the incident. The facility staff nurse stated she may have received a text from evening staff regarding the resident's wounds, then the next day the facility nurse and administrative staff looked at the resident's feet together. The facility nurse stated the wounds were discussed

during daily staff meetings and no one reported observing the wounds prior to the day they were reported. The facility staff nurse stated the facility had since initiated skin audits to ensure staff-skin observation was completed.

During an interview, the administrative nurse stated the wounds were reported to him by administrative staff and a facility nurse. The administrative nurse stated he treated the wounds then called to schedule the skilled nursing evaluation. Administrative staff stated during a facility meeting, staff were re-trained on skin observation and reporting. The administrative nurse stated staff were training during daily meetings to ensure skin observations are completed.

During an interview, the family member stated the resident had side effects from diabetes such as, callouses and dry skin on her feet and she was not aware of any wounds on her feet prior to the hospitalization. The resident discharged to a higher level of care after the incident.

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, due to cognitive deficits.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The resident visited the podiatry provider on recommended scheduled visits.
Reported the wounds to the resident’s provider and family.
Completed an assessment.
Treated the wounds.
A skilled nursing evaluation was completed on the resident’s wounds.
The resident was transported to the hospital for further evaluation of the wounds.

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
	31675	A. BUILDING: _____ B. WING _____	C 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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 December 8, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL316758824C/#HL316758102M. No correction orders are issued.	0 000		