Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205513712M
Compliance #: HL205513591C

Date Concluded: October 13, 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:
Lacey Eggersdorfer, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 assess and clean a wound on the resident's toe, resulting the wound being infested with maggots.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility failed to assess the resident's injury, provide basic first aid, and notify the resident's hospice care team. The resident's hospice care team arrived the next day to care for the resident and found her foot to be covered in blood and maggots.

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 records, hospital records, personnel files, staff schedules, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure and diabetes. The resident's service plan included assistance with bathing and grooming. The resident's assessment indicated she was alert and oriented and received hospice care services.

Medical records indicated the resident had snagged her toenail in the morning and had partially torn the nail off. She reported the injury to an unlicensed staff member, but the wound was not cleaned or assessed by facility staff. The next day, the resident's hospice care team arrived and found her foot covered in dried blood as well as maggots found underneath her toenail and in between her toes. Medical records indicated facility staff were aware of the resident's injury.

Progress notes did not acknowledge the resident's injury or indicate that they notified the resident's hospice care team of an injury that needed attention.

Service delivery records indicated there were three different unlicensed staff members in the resident's apartment the day of her injury, and services were provided five times over the course of the day. Service delivery records indicated one of those services was for the resident's skin check, with instructions to alert nursing of any concerns.

Training records indicated the unlicensed staff that provided services to the resident that day were trained in basic first aid wound care.

In an interview, unlicensed staff stated she noticed the resident had blood coming from her foot when she was administering her medication. She reported the wound to licensed staff who told her the resident had a scheduled hospice team visit the next day and that they will address the wound at that time. She had seen the resident before the end of her shift and the next day before the resident's hospice appointment, and the resident's toe was still bloody. The resident told unlicensed staff no one had assessed or cleaned her toe all day. Unlicensed staff stated cleaning wounds was not something she was required to do.

In an interview, licensed staff denied awareness of the resident's injury. Both licensed and unlicensed staff are trained to cleanse wounds and provide basic dressings in the facility. It would be expected that facility staff clean and asses a resident's wound upon being informed of it. Licensed staff believed the resident's wound would have been noticed by facility staff as they were frequently providing care to the resident in her room. Licensed staff also acknowledged it was their responsibility to notify the resident's hospice care team if the resident needed immediate management of an injury that was outside the facility's scope of practice.

In an interview, family members stated they were concerned about the resident's care when they learned that maggots had infested her wound.

The resident was unable to be interviewed due to passing away shortly after the incident from unrelated causes.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility staff sanitized the resident’s apartment and discarded soiled wound dressings.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

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 09/14/2026

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL205513591C/HL205513712M #HL205513871C/HL205513969M On 9/14/26, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 59 residents receiving services under the provider 's Assisted Living with Dementia Care license. The following correction order is issued for #HL205513591C/HL205513712M, and #HL205513871C/HL205513969M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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02360	Continued From page 2	02360	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	