MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202502136

Date Issued: March 4, 2026

Name and Address of Facility Investigated:

Disposition: Inconclusive

Wingspan Life Resources
1307 Skillman Ave. W.
Roseville, MN 55113

Wingspan Life Resources
30 Plato Blvd. E.
St. Paul, MN 55107

License Number and Program Type:

1069354 -H_CRS (Home and Community-Based Services-Community Residential Setting)
1069342-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that two vulnerable adults (VA1 and VA2) were not provided with adequate care when they did not see a podiatrist for nine months for toenail care.

Date of Incident(s): Ongoing between June 2024 and March 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):

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 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 which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during site visits conducted on March 27 and April 4, 2025; from documentation at the facility and medical records; and through 14 interviews conducted with three facility supervisory staff persons (P1–P3), five staff persons (P4–P8), a facility registered nurse (RN), VA1's guardians (G1 andG2) who were also VA1's family members, VA2's former case manager (CM), and a representative (R) from a podiatry clinic.

VA1's diagnoses included metachromatic leukodystrophy, mild intellectual disorder, and cognitive disorder. (According to mayoclinic.org, metachromatic leukodystrophy is a genetic disorder in which the brain and nervous system progressively lose function.) VA1 enjoyed attending his/her day program, going into the community, and spending time with G1–G2.

VA1's *Client Profile* stated that staff persons were to "prompt" VA1 to shower offering VA1 assistance as needed. Staff persons were to perform a body check on VA1 and document any injuries to VA1 in the Health Progress Notes (HPN). VA1 also required staff persons "physical assistance" for his/her nail care.

VA1's *Intensive Support Self-Management Assessment* stated that staff persons assisted VA1 with scheduling all medical and dental appointments and were to accompany VA1 to all appointments, and ensure all medications, orders, and treatments were followed. VA1 was "unable to manage/schedule medical, dental or preventative screening appointments or procedures."

VA1's *Individual Abuse Prevention Plan* stated, "[VA1] required full physical assistance from staff most of the time to complete [his/her] hygiene tasks."

VA1's *Support Plan* stated that staff persons were to support VA1 with bathing, dressing, and grooming tasks to meet his/her needs. Staff were to contact VA1's case manager or guardians with any concerns. A facility "nurse will complete [VA1's] grooming tasks of nail care and cutting."

VA2's diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) after a stroke, intellectual disability, osteoporosis of his/her spine, and osteopenia of his/her hip, and spondylosis lumbosacral (a small crack between vertebrae). VA2 enjoyed watching TV, word finds, coloring, and doing crafts.

VA2's *Client Profile* stated staff persons were to "physically assist" VA2 with nail care.

VA2's *Support Plan* and *MnCHOICES Planning Summary* provided consistent information that staff persons were to assist VA2 with his/her nail care, "prompt" VA2 to shower and offer VA2 assistance as necessary. Staff persons were to perform a body check on VA2 and note any injuries to VA2 in the HPNs. Staff persons were to schedule and attend VA2's medical appointments and were to follow through with all recommendations made by his/her medical providers.

VA1 thought living at the facility was "good," and staff persons treated him/her "with respect." VA1 got along with staff persons "depending on the day." VA1 liked to go out into the community with staff persons for meals and coffee. Staff persons helped VA1 with "day to day" items, but s/he was able to shower, dress, and get ready for the day and bed "all by myself." VA1's feet were "fine," and s/he did not ever have pain or discomfort with his/her feet and/or toenails. If VA1 had pain or issues with his/her feet/toes s/he would tell G2 and staff persons and go to a podiatrist.

VA2 "like[d]" living at the facility. VA2 liked to watch TV and go out into the community with staff persons. Staff persons helped VA2 shower but did not look at VA2's feet "very often." VA2 dressed independently including putting on and taking off his/her socks and shoes. VA2 said his/her feet were "excellent," and denied having any issues with her feet/toes in the last year. P3 scheduled VA2's medical appointments and a staff person took VA2. VA2 recalled a podiatrist coming to the facility to cut his/her toenails but did not know why it stopped, and "staff usually" cut his/her toenails. VA2 denied pain or discomfort with his/her toenails at any time. VA2 did not remember his/her toenails being long, broken, or preventing him/her from wearing usually shoes and socks.

G1 and G2 provided the following information:

- VA1 had neuropathy in his/her in one or both of his/her legs or feet so it was unknown if VA1 was aware s/he had pain or was uncomfortable unless s/he was "really hurting" or in "debilitating" pain. VA1 required staff persons assistance with showering and dressing including putting on his/her shoes and socks so staff persons should see VA1's feet "every day." The facility arranged for a podiatrist to come to the facility on an ongoing basis every month or two for all the clients' podiatry needs.

- On an unknown date in late February or early March 2025, G1 and G2 were in the community with VA1 when VA1 became incontinent. G1 and G2 then brought VA1 back to the facility to clean VA1 and while in the bathroom, G2 took off VA1's shoes and socks. At that time, G2 saw that VA1 had a swollen ankle and his/her toenails were "purple, black, and blue" and looked like they had not been cut "in a while" because they were "long and curled up and down" and pointed them out to G1.

- G1 and G2 were concerned about possible infection and called VA1's primary clinic to schedule an appointment to have VA1's nails evaluated. G2 was told that VA1's primary care clinic did not do nails, but G2 kept the appointment so VA1 could be seen. G2 also called a podiatry clinic and scheduled an appointment for the VA on March 28, 2025. G2 then called P3 and told him/her about the conditions of VA1's nails and that they had scheduled appointments for VA1 to be seen. P3 said the staff persons "try out best" and that s/he "doesn't always see [VA1's] feet."

- On March 6, 2025, P3 brought VA1 to the primary care appointment with G2 was on speakerphone. The doctor said VA1's foot "was no longer swollen and the black and blue [was] gone" and there was "maybe a little red." The nurse said the purple color was gone from the edges of VA1's toenail beds. G1 stated that the doctor was "concern[ed]" that the toenails were "so bad" they needed to be "removed]" and referred VA1 to a podiatrist. G1 and G2 then told P1 about the situation and at that time they were told the HCP stopped coming to the facility about "six months or longer," possibly since the Spring 2024.

- On March 20, 2025, G1 and G2 received an email from P3 stating that s/he took VA1 to a different podiatrist that day and the podiatrist "clipped or filed" VA1's toenails, and said they were "fine" and there was no need to remove them. VA1 was not given any medications or prescribed any treatment for his/her feet and toenails.

[Note: At no time, did G1, G2, or any staff person take pictures of the condition of VA1's and/or VA2's toenails.]

P3 provided information that was consistent with the information provided by G1 and G2 and the following additional information:

- On March 6, 2025, at VA1's appointment with his/her primary doctor, P3 looked at and saw that VA1's toenails "did not look the best," were "yellow," "some were longer and thicker," and one was "growing over [his/her] toe."

- On an unknown date after learning about the conditions of VA1's toenails, P3 looked at VA2's toenails, which "looked okay, they weren't the best." VA2's toenails were "not much overgrown," but "a couple were broken." VA2's toenails "were not the worse, some were longer than others, but not much overgrown."

- On March 20, 2025, VA1 and VA2 were taken to a podiatrist and their nails were trimmed and did not need to be removed.

- In February or March 2024, when P3 started as a facility supervisor, G1 and G2 scheduled and attended "most" of VA1's appointments and then updated P3. P3 scheduled VA2's appointments, staff persons attended those with VA2, and after, P3 entered in the paperwork and referrals. "Every few months," the RN reviewed the notes and indicated what follow up or scheduling needed to be done. Between April 5, 2024, and March 20, 2025, P3 was unaware of VA1 and/or VA2complaining of pain or discomfort regarding their toenails, an inability for VA1 and VA2 to wear normal shoes and socks, or any staff persons having concerns about VA1's and/or VA2's toenails.

- VA1 told staff persons s/he was capable of completing more activities of daily living than s/he was able. Staff persons prompted VA1 with dressing and were with VA1 the "whole time" s/he showered. VA1 was reliant on staff persons for his/her cares but could "sometimes change [his/her] clothes." Staff persons "often" saw VA1's feet when s/he showered and when VA1 was getting ready for bed. The overnight staff person assisted VA1 to get ready in the morning and were there to assist if VA1 needed help putting on shoes and socks. VA1 was "able" to say if s/he was in pain when asked.

- VA2 was "more independent," received staff person support to wash his/her hair when s/he showered and dressed him/herself independently.

- Staff persons were to note anything unusual about VA1's and/or VA2's body or health in the progress notes and call or text P3 "anytime." If there was something unusual on VA1's and VA2's body, a staff person was to do an *Incident Ticket* which included a body scan to document the item.

- On an unknown date in April 2024, the podiatrist came to the facility to care for VA1's and VA2's toenails. The podiatrist was scheduled to return in June 2024, but "canceled" the appointment. P3 did not know how often the podiatrist came to the facility, was "not sure" who the podiatrist was, and "did not see the information" when s/he looked for it.

P3 was not sure how toenails were to be monitored. P3 did not shower VA1 often and VA1 was usually dressed when P3 arrived at work. P3 did not recall the last time s/he saw VA1's nails prior to G2's concerns and neither VA1 nor VA2 mentioned any toenail pain or discomfort.

P1 provided information that was consistent with the information provided by G1, G2, and P3, and the following additional information:

- In February or March 2024, P3 began working at the facility. On April 5, 2024, the podiatrist came to the facility, cared for VA1's and VA2's toenails, and an appointment was scheduled for the podiatrist to return on June 9, 2024. This appointment "was cancelled" for "some reason" by the podiatrist. P1 did know why the appointment was canceled and/or why it was not rescheduled. No additional podiatrist appointments made for VA1 and VA2. From April 5, 2024, to the investigation, P1 was not aware of eitherVA1 or VA 2 having any complaints or concerns with their toes or toenails. No staff persons told supervisory staff person about any issues or concerns with VA1's and/or VA2's toe or toenails.

- On March 13, 2025, P1 went to the facility and looked VA2's nails which "weren't bad," they were "super thick," and "most were short." P1 thought they might have "broke," VA2 maybe "picked at them," or s/he tried to clip them his/herself.

- Due to VA1's diagnoses, s/he "does not relay pain." Typically, if "something were off" with VA1, staff persons "noticed" it "most of the time." VA1 indicated pain when s/he "cr[ied] or rub[bed]" a body part and might ask staff to "look at" whatever the issue was. Staff persons had to use their "judgement" with what might be going on with VA1 and then follow up on the issue.

- VA2 "like[d] to do things on [his/her] own" including dressing his/herself. VA2 also did not want staff persons in the bathroom with him/her but staff persons assisted with showering.

- Staff persons were trained and "should be looking for any abnormalities on client's body" and to "relay [that] information" to management. Staff persons were to "notice" if "toenails were too long, red, or infected."

- The RN went to the facility "every few months" to review client information and note what appointments were due or missed. Staff persons then either scheduled the appointment and if VA1 needed an appointment G1 and G2 were notified and they scheduled it. The RN "usually" sent a copy of his/her notes to P1. The RN's "main role" while at the facility was "track" and "review appointments." When P1 reviewed the *Nurse Notes* there "never was an indication of gaps" for podiatry services for VA1 and/or VA2.

- Other residential programs operated by the same license holder typically included on a clients *Medication Administration Record* checking a client's toenails and fingernails monthly, but this was not done at the

facility and P1 was "not sure why" or how it was "missed." Nail care was "usually" scheduled the 15th of every month where staff persons assessed clients' nails for any "abnormalities" to be documented. A staff person in P3's position was to ensure the nail checks were done and follow up as needed.

P2 provided information that was consistent with the information provided by G1, G2, and P3 and the following additional information:

- P2 began working for the license holder approximately two weeks prior to G1's and G2's concerns regarding VA1's toenails. P2 did not know how often the RN went to the facility, what s/he specifically looked at while there, or if s/he met with the clients. The RN left notes of overdue and follow up items and P2 reviewed the items with P3 and confirmed when they were completed. The RN used an appointment frequency tracker for VA1 and VA2 and P3 was to create his/her own version.

- On March 13, 2025, P1 and P2 went to the facility to look at VA1's and VA2's toenails. VA1's and VA2's toenails "did not look good," and were "longer than should be... thick... hard... yellow," but "not crazy long." P2 read through progress notes for VA1 and VA2 but did not find anything regarding their toenails. P2 was not aware VA1 and VA2 used podiatry services until s/he looked through the records and found entries on April 5, 2024, and determined "nothing" was being done by staff persons to monitor VA1's and VA2's toenails.

- On March 20, 2025, VA1 and VA2 saw a podiatrist who trimmed their toenails and none needed to be removed.

- After learning of the situation, P2 spoke with all staff persons at the facility regarding monitoring VA1's and VA2's toenails, doing body scans while staff persons assisted VA1 and/or VA2 in the shower, and tracking monthly on the *Medication Administration Record (MAR).*

The RN provided information that was consistent with the information provided by P3, G1, and G2 and the following information:

- The RN went to the facility every two to three months and reviewed health notes, including MARs and HPNs for each client. The RN looked at each client's "list of appointments," including "medical materials" such as appointment after visit summaries, health progress notes, and MARs for changes since his/her last review. If VA1 and VA2 were at the facility when the RN was, s/he talked with them to "maintain a good relationship," but did not go into health-related items with them or examine them. It was P3's "primary responsibility" to track medical appointments frequency, and the RN was the "secondary" and operated as a "double check." If there was an appointment missing or overdue, the RN told P3. P3 was also to train staff persons on nail care and then staff persons could perform the nail care as required by each client.

- The podiatrist began coming to the facility prior to July 2013 to care for VA1's and VA2's toenails. The RN did not know why the podiatrist appointment for June 2024 was canceled and/or why no additional appointments were made.

- The RN was not aware of any complaints by VA1 and VA2 about pain or discomfort with their toenails and was now aware of any issues with VA1's and/or VA2's toenails until an unknown date in March 2025.

VA1's and VA2's podiatrist appointment summary of exam and diagnosis dated April 5, 2024, each stated, "examined foot and nails, long toenails, trimmed and debrided nail." The next appointments were scheduled for June 9, 2024, at 4 p.m.

The RN's *Nursing Visit* forms dated May 8, 2024, stated VA1 and VA2 had podiatry appointments on April 5, 2024.

The R stated the podiatrist "depend[ed]" on the facility to schedule appointments and the last appointment was April 5, 2024. There were "no more requests for services after April" and the R was "not sure what happened." The podiatrist retired in early January 2025. (Note: This was seven months after the canceled appointment for VA1 and VA2.)

P4–P8 provided the following information:

- Staff persons assisted VA1 with his/her showers and dressing so they would have seen VA1's toenails, but no one saw anything unusual or concerning. VA2 showered and dressed independently so staff persons did not see VA2's toenails.

- P5 stated that VA1's toenails were "not like (P5's) regular toenails," they were "brown-ish" and "like dried off or something like that," "not like real toenails at all." P5 did not see that VA1's toenails were overgrown or curled. P5 thought the condition of VA1's nails were "just normal" for VA1.

- P4–P8 each stated they were not trained on nailcare for VA1 and/or VA2 and neither VA1 nor VA2 said they had any concerns with pain or discomfort with their toenails.

The CM provided the following information:

- Staff persons were to assist VA2 with grooming and dressing, but VA2 showered independently. VA2 told staff persons if s/he was in pain or had discomfort but would likely decline medical care. VA2 never said anything to the CM about staff persons not taking care of his/her toenails.

- The CM thought the facility was run well and VA2 was "well cared" for and staff persons were able to care for VA2's toenails unless there were medical reasons why they should not, and then a podiatrist should be seen.

Facility documentation showed that on March 20, 2025, VA1 and VA2 were each seen by a podiatrist. The documentation was signed by the podiatrist and stated:

- VA1's toenails were cut, "recommend no medication," "recommend no removal," and "simple follow up as needed." VA1's next appointment was as needed.

- VA2's toenails were cut, "no other treatment needed at this time," and "recommend follow up as needed." VA2's next appointment was as needed.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D.05, subdivision 1, paragraph (a), states the license holder is responsible for meeting health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum, consistent with the person's health needs.

Conclusion:

VA1's and VA2's plans each stated that staff persons were responsible for scheduling and attending VA1's and VA2's medical appointments and for "physically assisting" each with toenail care. Between at least 2013 through April 5, 2024, a podiatrist regularly came to the facility and cared for VA1's and VA2's toenails. An appointment, scheduled for June 9, 2024, was cancelled by the podiatrist but no follow up appointments were made and VA1 and VA2 did not receive toenail care until 11 months later on March 20, 2025. This was a violation of Minnesota Statutes, section 245D.05, subdivision 1, paragraph (a).

Information from all sources was consistent that during this time, neither VA1 nor VA2 complained of pain and/or discomfort with their toenails and they were able to wear regular shoes and socks. On unknown dates, in February or March 2025, VA1's and VA2's toenails were seen and appeared to be overgrown, broken, and/or discolored. There were no pictures to show the condition of VA1's and/or VA2's toenails and when each was seen on March 20, 2025, by the podiatrist, their toenails were cut by the podiatrist and neither required additional care and/or follow up.

Although it was reasonable that the facility would have scheduled and/or ensured toenail care for VA1 and VA2 and that each went 11 months without toenail care, given that neither had complaints of pain and/or discomfort and that neither required care for the toenails other than cutting, there was not a preponderance of the evidence whether there was a failure to supply VA1 and VA2 with care or services which were reasonable and necessary to obtain or maintain VA1's and/or VA2's physical health.

It was not determined whether neglect occurred (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 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 which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. The facility updated VA1's–VA2's MAR to include regular documented monitoring of toenails. P3 was to schedule VA1 and VA2 to be regularly seen by podiatry. All staff persons were informed it was their individual responsibility to monitor VA1's and VA2's toenails and follow protocols.

Action Taken by Department of Human Services, Office of Inspector General:

On March 4, 2026, the facility was issued a Correction Order for the violation outlined in this report.