



*Protecting, Maintaining and Improving the Health of All Minnesotans*

## NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

August 15, 2025

Licensee

Anchor Care Services LLC  
8425 69th Street South  
Cottage Grove, MN 55016

RE: Denial of License Number 416833  
Health Facility Identification Number (HFID) 40863  
Initial survey; Project Number SL40863015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on June 12, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

### STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

### REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.



## **REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS**

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than Monday August 18, 2025**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

Sincerely,



Rick Michals, J.D.

**Executive Regional Operations Manager**

**Minnesota Department of Health**

**Health Regulation Division**

HHH



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 000                                                               | <p>Initial Comments</p> <p>***ATTENTION***</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL40863015-0</p> <p>On June 9, 2025, through June 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Provisional Assisted Living Facility license.</p> <p>An immediate correction order was identified on June 11, 2025, issued for SL40863015-0, tag identification 1760.</p> <p>During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.</p> | 0 000                                                                  | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p> |  |                                                     |
| 0 480<br>SS=F                                                       | <b>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 480                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                     |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                               | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, | 0 480                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                               | <p>Continued From page 2</p> <p>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br/>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br/>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> | 0 480                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                               | Continued From page 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 480                                                                  |                                                                                                                          |  |                                                     |
| 0 510<br>SS=F                                                       | <p><b>144G.41 Subd. 3 Infection control program</b></p> <p>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for two of three employees (unlicensed personnel (ULP)-D, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                               | <p>Continued From page 4<br/>of the residents).</p> <p>The findings include:</p> <p><b>ULP-D</b><br/>ULP-D was hired November 7, 2024, to provide assisted living services.</p> <p>On June 10, 2025, at 8:57 a.m., the surveyor observed ULP-D sitting at a computer placed in the main area of the facility completing documentation. ULP-D then put on gloves without completing hand hygiene and went into the basement to provide cares for R1.</p> <p><b>CNS/LALD-A</b><br/>CNS/LALD-A was hired May 23, 2024, to provide assisted living services clinical oversight.</p> <p>On June 10, 2025, at 9:24 a.m., the surveyor observed CNS/LALD-A put on gloves with without completing hand hygiene. CNS/LALD-A then took medications belonging to R1 and dumped them out onto the paper inside of a three-ring binder on CNS/LALD-A's desk. The three-ring binder was utilized as a policy binder and was not clean prior to having medications dumped on it and due to the porous surface would not be able to be sanitized.</p> <p>On June 12, 2025, at 11:01 a.m., CNS/LALD-A stated staff are trained to complete hand hygiene before putting on gloves, after taking off gloves, and in between glove changes.</p> <p>On June 12, 2025, at 11:03 a.m., CNS/LALD-A stated they should have placed R1's pills on a clean paper towel. CNS/LALD-A stated they were not really thinking about it.</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                               | <p>Continued From page 5</p> <p>The licensee's undated Standard Precaution for All Health Care Workers policy indicated gloves should be changed after each resident contact. When gloves are removed, thorough hand washing is required.</p> <p>The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, subsection 5a. Hand Hygiene References and resources indicated the following:</p> <p>1. Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations.</p> <p>2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications:</p> <p>    a. Immediately before touching a patient</p> <p>    b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices</p> <p>    c. Before moving from work on a soiled body site to a clean body site on the same patient</p> <p>    d. After touching a patient or the patient's immediate environment</p> <p>    e. After contact with blood, body fluids or contaminated surfaces</p> <p>    f. Immediately after glove removal</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |
| 0 660<br>SS=F                                                       | <p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 6</p> <p>program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), for three of three staff (clinical nurse supervisor licensed assisted living director (CNS/LALD)-A, unlicensed personnel (ULP)-D and ULP-G).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's TB facility risk assessment dated January 14, 2025, indicated the licensee was a</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 7</p> <p>low risk.</p> <p>CNS/LALD-A<br/>CNS/LALD-A was hired May 23, 2024, to provide assisted living services and clinical oversight.</p> <p>CNS/LALD-A's employee record contained a QuantiFERON-TB Gold blood test dated March 17, 2023, with a negative result.</p> <p>CNS/LALD-A's employee record lacked documentation of a symptom screening.</p> <p>ULP-D<br/>ULP-D was hired November 7, 2024, to provide assisted living services.</p> <p>ULP-D's employee record contained a TB symptom screening completed on October 29, 2024, and a QuantiFERON-TB Gold Plus test dated May 20, 2024, with a negative result. This indicated more than 90-days had lapsed since ULP-D's QuantiFERON-TB Gold Plus test and their symptom screening/date of hire.</p> <p>ULP-G<br/>ULP-G was hired April 8, 2025, to provide assisted living services.</p> <p>ULP-G's employee record contained a TB symptom screening completed on April 9, 2025, and a QuantiFERON-TB Gold blood test September 26, 2024, with a negative result. This indicated more than 90-days had lapsed since ULP-G's QuantiFERON-TB Gold Plus test and their symptom screening/ date of hire.</p> <p>On June 12, 2025, at 11:06 a.m., CNS/LALD-A stated they were under the assumption that blood tests may be utilized when they are over a year</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 8</p> <p>old, and this was the reason they had been accepting blood tests greater than 90 days old.</p> <p>The licensee's undated Tuberculosis Screening policy indicated all employee's, volunteers or contract personnel providing direct resident care shall have evidence of a baseline TB screening consisting of two components, a symptom screening and testing for the presence of active TB disease. Testing for the presence of infection would be tested by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire.</p> <p>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |
| 0 680<br>SS=F                                                       | <p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                               | <p>Continued From page 9</p> <p>requirements:</p> <p>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                               | <p>Continued From page 10</p> <p>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On June 9, 2025, at 11:05 a.m., the surveyor retrieved the licensee's emergency preparedness plan (EPP) from clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A for review. The surveyor observed the licensee's EPP was stored in the basement nursing office behind a lockable door. The licensee failed to post an emergency disaster plan prominently.</p> <p>The licensee's written emergency disaster preparedness plan lacked evidence of the following required content:</p> <ul style="list-style-type: none"><li>- Policies and procedures to identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care;<ul style="list-style-type: none"><li>-The licensee's EPP contained a policy describing the procedure of printing out information packets containing resident information for emergency purposes, but there were no print outs available at time of survey;</li></ul></li><li>- Subsistence needs for staff and patients;<ul style="list-style-type: none"><li>- The licensee's EPP contained a blank template which indicated it was to be completed on an annual basis;</li></ul></li><li>- Policies and procedures for medical documents;<ul style="list-style-type: none"><li>- The licensee's EPP contained a policy describing the procedure of printing out information packets containing resident information for emergency purposes, but there were no print outs available at time of survey;</li></ul></li><li>- Name and contact information of staff, entities</li></ul> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                    |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                               | Continued From page 11<br><br>providing services under agreement, residents' physicians, other facilities, and volunteers; and,<br>- Emergency official contact information.<br><br>On June12, 2025, at 11:06 a.m., CNS/LALD-A stated they and the administrator were responsible for the development of the licensee's EPP. CNS/LALD-A stated they were not aware the complete EPP needed to be prominently posted and had attempted to have the EPP customized to the facility.<br><br>The licensee's 2.01 Policies & Procedures Overview dated December 9, 2024, indicated the emergency plan will be developed and made widely available to all staff. This plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually. The Emergency Plan is Incident Command System (ICS) compliant.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680                                                                                              |                                                                                                                          |  |                                                     |
| 0 700<br>SS=F                                                       | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 700                                                                                              |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 700                                                               | <p>Continued From page 12</p> <p>by:<br/>Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On June 9, 2025, at 11:05 a.m., during a tour of the facility the surveyor observed a printed document with hand written notes taped to the wall behind the licensee's computer which was used by staff for the purpose of notifying staff of R1's sliding scale insulin. The form was located on the main floor in the living room shared by all residents and visitors. The document contained the name of R1 as well as R1's prescribed insulin sliding scale and was easily visible.</p> <p>On June 10, 2025, at 9:14 a.m., after verifying medications on the licensee's computer, the surveyor observed ULP-D leave the computer unlocked and unsecured with R1's medical record displayed while ULP-D administered medications in the basement of the facility. The computer was left logged into and also could have been accessed by unauthorized users.</p> <p>On June 12, 2025, at 11:09 a.m., clinical nurse supervisor/licensed assisted living director</p> | 0 700                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 700                                                               | Continued From page 13<br><br>(CNS/LALD)-A stated all staff were trained to secure computer monitors when not in use. Additionally, CNS/LALD-A stated R1's sliding scale should not have been posted in the main living area of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 700                                                                  |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                       | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                               | <p>Continued From page 14</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On June 10, 2025, from 2:30 p.m. to 4:30 p.m., with clinical nurse specialist/licensed assisted living director (CNS/LALD)-A; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN:<br/>The licensee's FSEP, titled "Fire Safety Procedure", undated, failed to include the following:</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                               | <p>Continued From page 15</p> <p><b>STAFF ACTIONS:</b><br/>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility.</p> <p><b>RESIDENT ACTIONS:</b><br/>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.</p> <p><b>UNIQUE AND UNUSUAL RESIDENT NEEDS:</b><br/>The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.</p> <p>On June 10, 2025, at 3:30 p.m., CNS/LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.</p> <p><b>DRILLS</b><br/>The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. CNS/LALD-A stated they were doing drills with all 3 shifts for convenience.</p> <p>On June 10, 2025, at 3:30 p.m., ALDIR stated</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                               | Continued From page 16<br><br>there were no additional documented drills for the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 01290<br>SS=F                                                       | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) prior to staff providing services for five of seven employees (house manager (HM)-C, unlicensed personnel (ULP)-D, ULP-H, ULP-I, ULP-J)).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01290                                                               | <p>Continued From page 17</p> <p>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>HM-C<br/>HM-C was hired February 5, 2025, to provide assisted living services and management related tasks.</p> <p>HM-C's employee record contained a background study clearance dated February 5, 2025, affiliated to licensee's sister facility HFID# 39662. HM-C's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey.</p> <p>During the survey the surveyor observed HM-C provide transport assistance to residents and deliver prescriptions to the facility. HM-C completed the tasks in an unsupervised capacity and was observed to have uninhibited access to the facility.</p> <p>ULP-D<br/>ULP-D was hired November 7, 2024, to provide assisted living services.</p> <p>ULP-D's employee record contained a background study clearance, dated November 7, 2024, affiliated to licensee's sister facility HFID# 39662. ULP-D's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the</p> | 01290                                                                                              |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01290                                                               | <p>Continued From page 18</p> <p>current HFID number prior to the start of the survey.</p> <p>On June 10, 2025, from 8:54 a.m. to 10:11a.m., the surveyor observed ULP-D providing assisted living services to residents in an unsupervised capacity.</p> <p>ULP-H<br/>ULP-H was hired August 27, 2024, to provide assisted living services.</p> <p>ULP-H's employee record contained a background study clearance, dated September 5, 2024, affiliated to licensee's sister facility HFID# 39662. ULP-H's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey.</p> <p>ULP-I<br/>ULP-I was hired May 29, 2023, to provide assisted living services.</p> <p>ULP-I's employee record contained a background study clearance, dated May 23, 2023, affiliated to licensee's sister facility HFID# 39662. ULP-I's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey.</p> <p>ULP-J<br/>ULP-J was hired February 5, 2025, to provide assisted living services.</p> <p>ULP-J's employee record contained a background study clearance, dated January 30, 2025, affiliated to licensee's sister facility HFID#</p> | 01290                                                                     |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                               | Continued From page 19<br><br>39662. ULP-J's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey.<br><br>The licensee's undated Background Studies policy indicated facility employees, volunteers, or contractors who will provide direct care to residents must have a background study completed. The licensee's Background Studies policy did not address affiliating background studies to the licensee's HFID.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days                                                                                                                                                                                                                               | 01290                                                                  |                                                                                                                          |  |                                                     |
| 01610<br>SS=F                                                       | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered | 01610                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01610                                                               | <p>Continued From page 20</p> <p>planning and care delivery.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment using the uniform assessment tool on or before admission to the licensee for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1<br/>R1 was admitted November 8, 2024, to receive assisted living services.</p> <p>R1's diagnosis included adjustment disorder with mixed disturbance of emotions and conduct, delusional disorder, major depressive disorder, recurrent severe psychotic features, anxiety disorder, essential hypertension, type 2 diabetes with unspecified complications, heart failure, unspecified atrial flutter, unspecified asthma, mild disabilities, morbid obesity due to excess calories, insomnia due to other mental disorder, chronic pain syndrome, hyperlipidemia, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, acquired absence of left foot, Barret's esophagus with dysplasia, and</p> | 01610                                                                                              |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01610                                                               | <p>Continued From page 21</p> <p>hypokalemia.</p> <p>R1's service plan dated February 9, 2025, indicated R1 received assistance with dressing, as needed assistance with feeding, oral hygiene, grooming, toileting, bathing, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers, eating assistance, laundry, housekeeping, linen changes, and "I'm OK" check services.</p> <p>R1's contract signed on November 8, 2024, indicated an occupancy date of November 8, 2024.</p> <p>R1's record contained an admission assessment dated November 9, 2024, indicating one day had lapsed since R1's admission to the licensee at the time the assessment was completed.</p> <p>R2<br/>R2 was admitted September 15, 2024, to receive assisted living services.</p> <p>R2's diagnosis included mild cognitive impairment, sickle cell trait, moderate malnutrition, osteoporosis with current pathological fracture of right humerus, orthostatic hypotension, essential hypertension, anemia due to multiple mechanisms, tobacco use disorder, osteoarthritis of lumbar spine, unspecified spinal osteoarthritis complication status, mild non-proliferative diabetic retinopathy of left eye without macular edema associated with type 2 diabetes mellitus and late effects of CVA (cerebrovascular accident).</p> <p>R2's service plan dated September 18, 2024, indicated R2 received assistance with dressing,</p> | 01610                                                                                              |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01610                                                               | <p>Continued From page 22</p> <p>feeding, oral hygiene, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers, eating assistance, laundry, housekeeping, linen changes, and "I'm OK" check services.</p> <p>R2's contract dated September 15, 2024, indicated an occupancy date of September 15, 2024.</p> <p>R2's record contained an admission assessment dated September 18, 2024, indicating three days had lapsed since R2's admission to the licensee at the time the assessment was completed.</p> <p>On June 12, 2025, at 11:18 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they believed that all assessments had been completed on the correct dates but were entered into the electronic medical record late. Additionally, CNS/LALD-A stated they understood assessments needed to complete upon admission, on or before day 14, and not to exceed 90 days thereafter.</p> <p>The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01610                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | Continued From page 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01620                                                                  |                                                                                                                          |  |                                                     |
| 01620<br>SS=F                                                       | <p><b>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</b></p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p> <p>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | <p>Continued From page 24</p> <p>completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for one of two residents (R1) and failed to ensure ongoing resident reassessments did not exceed 90 days for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1<br/>R1 was admitted November 8, 2024, to receive assisted living services.</p> <p>R1's diagnosis included adjustment disorder with mixed disturbance of emotions and conduct,</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | <p>Continued From page 25</p> <p>delusional disorder, major depressive disorder, recurrent severe psychotic features, anxiety disorder, essential hypertension, type 2 diabetes with unspecified complications, heart failure, unspecified atrial flutter, unspecified asthma, mild disabilities, morbid obesity due to excess calories, insomnia due to other mental disorder, chronic pain syndrome, hyperlipidemia, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, acquired absence of left foot, Barret's esophagus with dysplasia, and hypokalemia.</p> <p>R1's service plan dated February 9, 2025, indicated R1 received assistance with dressing, as needed assistance with feeding, oral hygiene, grooming, toileting, bathing, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers, eating assistance, laundry, housekeeping, linen changes, and "I'm OK" check services.</p> <p>R1's record contained an admission assessment dated November 9, 2024, and a 14-day assessment dated November 26, 2024, indicating 17 days had lapsed between admission assessment and 14-day assessment. R1's next assessment was dated February 28, 2025, which indicated 94 days had lapsed since R1's last assessment.</p> <p>R2<br/>R2 was admitted September 15, 2024, to receive assisted living services.</p> <p>R2's diagnosis included mild cognitive impairment, sickle cell trait, moderate malnutrition, osteoporosis with current pathological fracture of right humerus, orthostatic</p> | 01620                                                                                              |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | <p>Continued From page 26</p> <p>hypotension, essential hypertension, anemia due to multiple mechanisms, tobacco use disorder, osteoarthritis of lumbar spine, unspecified spinal osteoarthritis complication status, mild non-proliferative diabetic retinopathy of left eye without macular edema associated with type 2 diabetes mellitus and late effects of CVA (cerebrovascular accident).</p> <p>R2's service plan dated September 18, 2024, indicated R2 received assistance with dressing, feeding, oral hygiene, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers, eating assistance, laundry, housekeeping, linen changes, and "I'm OK" check services.</p> <p>R2's record contained a 14-day assessment dated October 2, 2024, and a 90-day assessment January 1, 2025, indicating 91 days had lapsed between assessments followed by a 90-day assessment dated April 2, 2025, indicating 91 days had lapsed since R2's previous assessment.</p> <p>On June 12, 2025, at 11:18 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they believed that all assessments had been completed on the correct dates but were entered into the electronic medical record late. Additionally, CNS/LALD-A stated they understood assessments needed to complete upon admission, on or before day 14, and not to exceed 90 days thereafter.</p> <p>The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the resident reassessment, and monitoring must be</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | Continued From page 27<br><br>conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01620                                                                  |                                                                                                                          |  |                                                     |
| 01760<br>SS=G                                                       | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) accurately transcribed or reconciled physician's orders and failed to ensure unlicensed personnel (ULP) were properly instructed and properly documented medication administration for one of four residents (R1). The | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 28</p> <p>lack of accurate transcription and medication reconciliation resulted in medication errors for R1.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee on November 8, 2024, to receive assisted living services.</p> <p>R1's diagnosis included adjustment disorder with mixed disturbance of emotions and conduct, delusional disorder, major depressive disorder, anxiety disorder, essential hypertension, type 2 diabetes with unspecified complications, heart failure, atrial flutter, asthma, morbid obesity due to excess calories, chronic pain syndrome, hyperlipidemia, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, acquired absence of left foot, Barret's esophagus with dysplasia, and hypokalemia.</p> <p>R1's Service Plan dated March 9, 2025, indicated R1 received assistance with dressing, as needed assistance with self-feeding, assistance with oral hygiene, assistance with hair care, assistance with grooming, assistance with toileting, medications reminders, medication administration, hands on assistance with transfers and mobility, eating assistance, weekly laundry, and housekeeping.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 29</p> <p><b>METOPROLOL TARTRATE</b><br/>R1's signed physician orders dated April 25, 2025, indicated to decrease the prescribed metoprolol tartrate to 25 milligrams (mg) two times per day. Metoprolol tartrate is medication that is prescribed for slowing down an elevated heart rate and lowering blood pressure. Potential side effects of the medication include bradycardia (dangerously slow heart rate) and hypotension (dangerously low blood pressure).</p> <p>On June 10, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-D go into the basement nursing office to retrieve R1's morning medications. After retrieving the medications, ULP-D went into R1's room, and without completing any medication checks against the medication administration record (MAR) began to administer medications, at which point the surveyor intervened and requested ULP-D verify the medications against the MAR.</p> <p>On June 10, 2025, at 9:04 a.m., while ULP-D verified R1's medications against the MAR, the surveyor observed there were two metoprolol tartrate orders that each indicated to take ½ tab (25mg) by mouth 2x daily. Both entries on the MAR were signed off by ULP as having been administered during previous administration periods. The RN failed to ensure the prescriber's order was transcribed accurately.</p> <p>Additionally, R1's pharmacy prepared comingled medication packets which contained metoprolol tartrate 50mg in both the AM medication packet and in the PM medication packet, which indicated R1 had been receiving at least two times the prescribed dose of metoprolol, but potentially up to four times the prescribed dose as the order was duplicated and signed by staff on the MAR.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 30</p> <p>The RN failed to reconcile the medications delivered by the pharmacy and administered to R1 by ULP.</p> <p>On June 10, 2025, at 9:19 am, clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated the duplicate order on R1's MAR was due to a clerical error but the medication inside the comingled pack was accurate as it came prepared from the pharmacy. Without verifying the correct dosage was on hand, CNS/LALD-A then authorized ULP-D to administer the medications as packaged to R1.</p> <p>On June 10, 2025, at 9:24 a.m., the surveyor again intervened and requested CNS/LALD-A not let their staff administer the available dose of metoprolol tartrate, as they had not verified whether it was the correct dose. The comingled medication packet contained an unidentified round small white scored pill with the marking of R-50. The outside of the comingled medication packet indicated it contained a 50mg metoprolol tartrate tablet.</p> <p>On June 10, 2025, at 9:52 a.m., CNS/LALD-A stated their plan was to cut the unidentified pill labeled R-50 in half and administer the medication to R1.</p> <p>On June 10, 2025, at 9:53 a.m., the surveyor requested CNS/LALD identify the unidentified pill labeled R-50 prior to cutting it in half. CNS/LALD-A attempted to identify the medication using online resources but was unable to determine which medication was the metoprolol tartrate within the packet with certainty. The surveyor then requested CNS/LALD-A call the pharmacy to verify the contents and identification of the medications in the comingled medication</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>40863 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>06/12/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ANCHOR CARE SERVICES LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8425 69TH STREET SOUTH<br>COTTAGE GROVE, MN 55016                               |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 31</p> <p>packet. The surveyor observed CNS/LALD-A call the pharmacy to identify contents of medication packet. The pharmacy verified the medication labeled R-50 was metoprolol tartrate 50mg. Additionally, the pharmacy stated they did not have the new order on file for R1's change in dosage of the metoprolol tartrate, which indicated R1 had been receiving twice the prescribed dose of metoprolol tartrate since April 25, 2025.</p> <p>INSULIN<br/>R1's signed physician order dated April 7, 2025, indicated R1 received insulin lispro 100 units per ml, 20 units subcutaneously at breakfast and lunch, and 10 units subcutaneously at dinner. The order indicated to hold if blood glucose (BG) was less than 120mg/dl. In addition, the order contained a sliding scale, which was direction to alter the administered dosage by adding an additional amount of insulin to the base dosage depending on the obtained BG level. The sliding scale order indicated to administer an additional 3 units of insulin if R1's BG was between 200-249mg/dl, 5 units if between 250-299mg/dl, 6 units if between 300-349mg/dl, 8 units if between 350-399mg/dl, and 10 additional units if 400mg/dl or above and then to notify the RN.</p> <p>Insulin Lispro is an injectable medication that promotes the increased absorption of blood glucose. This has the effect of decreasing an individual's blood sugar which can result in hypoglycemic (low blood sugar) symptoms when given too much or not administered as prescribed. Hypoglycemic symptoms may include but are not limited to profuse sweating, headache, irritability, nausea, dizziness, weakness, increased heart rate, loss of consciousness, seizure, and in severe cases coma and death.</p> | 01760                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>40863 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>06/12/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ANCHOR CARE SERVICES LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8425 69TH STREET SOUTH<br>COTTAGE GROVE, MN 55016                               |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 32</p> <p>On June 10, 2025, at 10:11 a.m., ULP-G took over for ULP-D to provide medications for R1 and obtained a blood glucose from R1. R1's blood glucose was 202mg/dl.</p> <p>On June 10, 2025, at 10:16 a.m., ULP-G stated R1 would receive additional insulin per their sliding scale.</p> <p>R1's June MAR listed 20 units lispro at 9:00 a.m., and 1:00 p.m., and 10 units lispro at 6:00 p.m. R1's additional sliding scale order was incorrectly transcribed to be administered at 9:00 p.m., and was not scheduled with the other prescribed doses per the physician's order. The RN failed to ensure the prescriber's order was transcribed accurately.</p> <p>On June 10, 2025, at 10:18 a.m., the surveyor requested ULP-G ensure R1 was supposed to receive additional insulin via a sliding scale with the RN prior to administration.</p> <p>On June 10, 2025, at 10:20 a.m., CNS/LALD-A verified R1 was prescribed a sliding scale for insulin for 9:00 a.m., 1:00 p.m., and 6:00 p.m., and gave ULP-G a directive to administer the prescribed dose.</p> <p>On June 10, 2025, at 10: 31 a.m., the surveyor observed ULP-G prepare to administer the prescribed dose of insulin for R1. ULP-G failed to clean the injection port of the insulin pen prior to placing the injection needle on the pen.</p> <p>On June 10, 2025, at 10:34 a.m., ULP-G stated they were not trained to clean the injection port of insulin pens prior to attaching injection needles to port. The surveyor instructed ULP-G to start over</p> | 01760                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 33</p> <p>and clean the injection port prior to placing a new injection needle on R1's injection pens.</p> <p>On June 10, 2025, at 10:40 a.m., the surveyor observed ULP-G administer the prescribed amount of insulin to the right lower quadrant of R1's abdomen.</p> <p>On June 10, 2025, at 3:37 p.m., CNS/LALD-A stated staff were using a printed-out guide that was posted to R1's wall for guidance on administering sliding scale insulin to R1. CNS/LALD-A stated there had been no documentation of administration of R1's sliding scale insulin dosages, as there was no location on the MAR for the information to be entered.</p> <p>In addition, R1's MAR contained the following direction:</p> <ul style="list-style-type: none"><li>- insulin aspart (a different type of insulin), give 20 units subcutaneously at 12:00 p.m., time with sliding scale. Hold if blood sugar is less than 120.</li></ul> <p>R1 did not have the medication available for administration, however, the medication was documented by the licensee's staff as having been administered during the month of May 2025, and June 2025. The medication was scheduled for a separate administration time than R1's scheduled insulin lispro which was scheduled for 1:00 p.m. The error in transcription, reconciliation, and documentation put R1 at an increased risk for medication errors and overdose of insulin.</p> <p>On June 10, 2025, at 3:37 p.m., CNS/LALD-A stated the insulin aspart order was an old order that had R1 was admitted with and had since been discontinued. CNS/LALD-A stated it was another clerical error on their behalf. Additionally, CNS/LALD-A stated staff often documented on medications without reading or paying attention to</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 34</p> <p>what they were documenting, and the above-mentioned medications were documented when there was no available stock for administration.</p> <p>The licensee's undated Medication Administration Error policy indicated the following:<br/>"Medication error shall be defined as, but not limited to:</p> <ul style="list-style-type: none"><li>- wrong medication</li><li>- wrong dose</li><li>- extra dose</li><li>- wrong time</li><li>- wrong route</li><li>- wrong person</li><li>- omission of ordered drug"</li></ul> <p>The licensee's undated Medication Prescriptions and Refills policy indicated the RN is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, are addressed in the resident's care plan, service plan and Medication Administration Record, and are communicated to all appropriate staff.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>This correction order was issued to the licensee via email on Wednesday, June 11, 2025, and the attached document incorrectly indicated a 7-day time period for correction. The email body and heading, however, correctly identified it was an immediate order for correction.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |
| 01890<br>SS=F                                                       | 144G.71 Subd. 20 Prescription drugs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01890                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01890                                                               | <p>Continued From page 35</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information and failed to ensure time sensitive medications were labeled with the date opened for one of four residents (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p><b>MEDICATION STORAGE</b></p> <p>On June 10, 2025, at 7:52 a.m., during an audit of the licensee's medication cart, the surveyor observed multiple medications stored outside of their original packaging. Clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated the medications belonged to R1. The following unidentified medications were observed in the medication bin belonging to R1:<br/>- one yellow capsule labeled "s618 300mg"</p> | 01890                                                                                              |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                               | <p>Continued From page 36</p> <p>- one white round scored tablet labeled "8 05"<br/>- one gray oval tablet labeled "m10"<br/>On June 10, 2025, at 8:20 a.m., CNS/LALD-A stated the medications should have been properly disposed of.</p> <p>TIME SENSITIVE MEDICATIONS</p> <p>On June 10, 2025, at 7:52 a.m., during an audit of the licensee's medication cart, the surveyor observed multiple time sensitive medications which belonged to R1 and lacked labeling to display the opened-on date:</p> <p>- Lantus Solostar 100units/ml<br/>- Humalog Kwikpen 100unit/ml<br/>- one bottle carboxymethylcellulose 0.5% solution<br/>- two bottles of refresh Optiv eye drops</p> <p>The manufacturer's instruction on carboxymethylcellulose 0.5% solution indicate to discard after 90-days after opening.</p> <p>The manufacturer's instructions on refresh Optiv eye drops indicate to discard after 90-days after opening.</p> <p>The manufacturer's instructions on Lantus indicate to dispose of insulin pens 28 days after opening.</p> <p>The manufacturer's instructions on Humalog Kwikpen indicate to dispose of insulin pens 28 days after opening.</p> <p>On June 10, 2025, at 8:18 a.m., CNS/LALD-A stated the two insulin pens in R1's medication bin were in current use. CNS/LALD-A stated staff were trained to label time sensitive medications upon opening using sticker labels, but that the licensee was currently out of stickers.</p> | 01890                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                               | Continued From page 37<br><br>The licensee's undated Medication Management Services policy indicated the registered nurse (RN) is responsible for the implementation of the facilities medication management policies and procedures. Additionally, the policy indicated the licensee would store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                      | 01890                                                                  |                                                                                                                          |  |                                                     |
| 02320<br>SS=F                                                       | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (unlicensed personnel (ULP)-D, ULP-G) followed appropriate medication administration procedures.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 02320                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02320                                                               | <p>Continued From page 38</p> <p>resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-D<br/>ULP-D was hired November 7, 2024, to provide assisted living services.</p> <p>On June 10, 2025, at 8:59 a.m., the surveyor observed ULP-D go into the basement nursing office to retrieve R1's morning medications. After retrieving the medications, ULP-D went into R1's room, and without completing any medication checks against the medication administration record (MAR) began to administer medications, at which point the surveyor intervened and requested ULP-D verify the medications against the MAR.</p> <p>On June 10, 2025, at 9:01 a.m., ULP-D stated they check the MAR prior to going into the basement to retrieve medications for administration.</p> <p>ULP-G<br/>ULP-G was hired April 8, 2025, to provide assisted living services.</p> <p>On June 10, 2025, at 10:31 a.m., the surveyor observed ULP-G prepare to administer insulin to R1 via R1's Humalog Kwikpen. The surveyor observed ULP-G place a needle on the insulin pen belonging to R1 without first cleaning the rubber seal. The surveyor intervened and directed ULP-G to remove the needle and clean the rubber seal with an alcohol swab prior to</p> | 02320                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40863</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b>                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02320                                                               | <p>Continued From page 39</p> <p>placing the needle. ULP-G stated they did not know they were supposed to clean the rubber seal prior to placing the injection needle.</p> <p>On June 10, 2025, at 10:48 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated that all staff were trained to clean the rubber seal of insulin pens prior to placing needles and were checked off by the nurse prior to being allowed to independently administer the medications. CNS/LALD-A stated they were unaware staff were not completing the task correctly.</p> <p>On June 12, 2025, at 11:22 a.m., CNS/LALD-A stated all staff were trained to checks medicationss against the MAR prior to administering and that staff had been repeatedly trained on it.</p> <p>The manufacturer's instruction for use pamphlet dated July 2023 for Humalog Kwikpen indicates that after removing the pen cap of the pen, the rubber seal should be wiped off with an alcohol swab.</p> <p>The licensee's undated Qualifications, Training and Competency policy indicated the following:</p> <p>"When the registered nurse or licensed health professional delegates tasks, they will ensure the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each resident, and are able to demonstrate the ability to competently follow the procedures and perform the tasks."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7)</p> | 02320                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                              |                                                                                                    |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40863</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANCHOR CARE SERVICES LLC</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8425 69TH STREET SOUTH<br/>COTTAGE GROVE, MN 55016</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02320                                                               | Continued From page 40<br>days                                                                                               | 02320                                                                                              |                                                                                                                          |  |                                                        |





Metro District Office  
Minnesota Department of Health  
625 Robert St N, PO BOX 64975  
St Paul, MN 55164  
Phone: 651-201-4500

## Food & Beverage Inspection Report

Page: 1

### Establishment Info

Anchor Care Services LLC  
8425 69th Street South  
Cottage Grove, MN 55016  
Washington County  
Parcel:  
  
Phone:

### License Info

License: HFID 40863  
  
Risk:  
License:  
Expires on:  
CFPM: Tonye Sylvanus  
CFPM #: FM115686; Exp: 03/25/2026

### Inspection Info

Report Number: F1004251041  
Inspection Type: Full - Single  
Date: 6/9/2025 Time: 11:00:27 AM  
Duration: minutes  
Announced Inspection:  
**Total Priority 1 Orders: 0**  
Total Priority 2 Orders: 1  
Total Priority 3 Orders: 0  
Delivery: Emailed

### New Order: 4-300 Equipment Numbers and Capacities

4-302.13B      *Priority Level: Priority 2   CFP#: 48*

*MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

**COMMENT: IRREVERSIBLE TEMPERATURE INDICATOR (WATER PROOF THERMOMETER) FOR USE WITH THE DISH MACHINE COULD NOT BE PRODUCED DURING INSPECTION. OPERATOR PROVIDED PROOF OF THERMOMETER TO INSPECTOR LATER THE SAME DAY. ENSURE THE IRREVERSIBLE TEMPERATURE INDICATOR IS READILY ACCESSIBLE AT ALL TIMES.**

*Comply By: 6/9/2025      Originally Issued On: 6/9/2025*

## Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY ZACH MORTH.

### DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- PREVENTING BAREHAND CONTACT WITH READY-TO-EAT FOOD ITEMS
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES
- PEST CONTROL
- LOGS (COOLER TEMPERATURE, COOKING TEMPERATURES, COOLING TEMPERATURES, SANITIZER CONCENTRATIONS, ETC)
- PHYSICAL FACILITIES AND MAINTENANCE

\*REPORT WAS DISCUSSED WITH THE OPERATOR, TONYE, AND WITH THE NURSE



---

EVALUATOR, ZACH.

\*FLOORS ARE LAMINATE, WALLS ARE SMOOTH PAINTED DRYWALL,, AND CEILING IS SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE GRANITE AND CABINETS ARE LAMINATE WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

\*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

\*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

---

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Metro District Office inspection report number F1004251041 from 6/9/2025**

---

Tonye Sylvanus

*Molly Dougherty*

---

Molly Dougherty,  
Public Health Sanitarian 3  
651-201-3978  
molly.dougherty@state.mn.us





Metro District Office  
Minnesota Department of Health  
625 Robert St N, PO BOX 64975  
St Paul, MN 55164

## Temperature Observations/Recordings

Page: 1

### Establishment Info

Anchor Care Services LLC  
Cottage Grove  
County/Group: Washington County

### Inspection Info

Report Number: F1004251041  
Inspection Type: Full  
Date: 6/9/2025  
Time: 11:00:27 AM

**Food Temperature:** **Product/Item/Unit:** Cheese; **Temperature Process:** Cold-Holding

**Location:** Refrigerator at 41 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature:** **Product/Item/Unit:** Ground Beef; **Temperature Process:** Cold-Holding

**Location:** Refrigerator at 41 Degrees F.

Comment:

*Violation Issued?: No*





Metro District Office  
Minnesota Department of Health  
625 Robert St N, PO BOX 64975  
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Anchor Care Services LLC  
Cottage Grove  
County/Group: Washington County

Inspection Info

Report Number: F1004251041  
Inspection Type: Full  
Date: 6/9/2025  
Time: 11:00:27 AM

**Sanitizing Equipment:** Product: Hot Water; **Sanitizing Process:** Dish Machine  
**Location:** Kitchen **Equal To** 176 Degrees F.  
Comment:  
*Violation Issued?: No*