

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396622824M
Compliance #: HL396621169C

Date Concluded: September 16, 2026

Name, Address, and County of Licensee

Investigated:

Anchor Care Services LLC
8443 81st St South
Cottage Grove, MN 55016
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The facility and alleged perpetrator (AP) neglected the resident when they failed to follow the resident's plan of care, which resulted in worsening wounds.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. While the resident did develop skin wounds while residing at the facility, the facility completed wound care as ordered, communicated changes to the resident's provider, and initiated interventions for prevention of wound worsening. The resident's wounds healed prior to the resident's discharge to a hospital.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident care manager and medical provider. The investigation included review of the resident's records, death record, hospital records, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes type two, high blood cholesterol, stroke, and depression. The resident's service plan included assistance with repositioning every two hours, safety checks every two hours, behavior management, wound care, meals, and incontinence care. The resident's assessment indicated the resident required use of a wheelchair for mobility and had moderate cognitive impairment with agitation and anxiety.

A facility incident report indicated pea sized redness was noted to the resident's buttocks and the resident's family member was notified. Interventions the facility implemented included barrier cream, repositioning, and a pressure mattress.

A subsequent wound assessment indicated two areas of concern, an intact blister located on the resident's left heel that measured one and a half centimeters by a half centimeter, and an open area on the resident's buttock that measured two centimeters by three and one third centimeters.

The resident's service delivery records indicated turning, repositioning and toileting were completed as ordered.

The resident's progress notes indicated the heel blister was noted upon return from a hospital stay, in which the resident's provider and family member were notified. The notes indicated wound care was completed daily as ordered.

The resident's care plan indicated skin interventions included foam boots to both feet, barrier cream, foam dressing, frequent repositioning, and wound care from a home care agency for skilled nursing staff were in place.

The resident's wound care notes from the home care agency indicated they started providing services when skin concerns were noted and discharged their services two months later due to the wounds closed.

An email received from the resident's care manager indicated she accessed the resident's wound clinic records that included a deep tissue injury to the heel that measured one centimeter by one centimeter. The skin was purple and intact. Approximately three weeks later, after a hospital stay and discharge to a nursing home, the same area measured three and half centimeters by eight centimeters and remained intact. The wound to the sacrum measured four centimeters by nine centimeters and was not intact. Approximately three weeks later, after a hospital stay and discharge to a nursing home, the sacrum wound measured five centimeters by 12 centimeters with tunneling under the skin and large amount of drainage.

The resident's hospital notes indicated the family member told a care manager she felt the facility cared for the resident well and did not want the resident moved to a nursing home. The

note indicated the family member acknowledged the nurse told her the resident needed higher care, was failing to thrive, and did not want to eat or drink.

Per facility records, the resident discharged to a nursing home after her last hospital stay.

The facility received a letter from the resident's family member indicating the family member was very satisfied with the care the resident received at the facility. In the letter, the family member indicated she observed firsthand the great care and support they provided for the residents and were impressed. The letter indicated the family member could confirm the owners were respectful, friendly, helpful and professional, and all the residents she met at the facility demonstrated how happy they were. The family member indicated she had rest of mind given the overall improvements in the resident's health because of the quality of care provided by the facility. Additionally, the family member indicated the facility kept her informed about everything happening, and the staff was not only efficient but also incredibly compassionate and treated each resident with the love and respect they deserved.

The resident's death record indicated the resident passed away almost two months after she discharged from the facility and listed coronary artery disease as the primary cause of death.

During an interview, the nurse stated the resident walked on her own and had no skin concerns at the time of admission. The nurse stated the facility was aware there was a camera present in the residents' room, and the family member would send her a picture of the resident sitting in her chair, laying down in bed, or getting up on her own. The nurse stated the resident was at the facility for three years when she started to decline, was agitated, refused care most of the time, was in bed most of the time and was adamant to not be repositioned. She told staff to get away from her and not touch her, which made it very difficult to reposition the resident. The nurse stated there were a few times the repositioning of the resident could not be completed due to the resident hitting the staff. The nurse stated the resident's skin developed redness and they started barrier cream with every brief change, pillows for positioning support, foam boots for heel protection, and ensured proper nutrition. The nurse stated the redness would heal and then come back. The nurse stated the resident's skin started to open after she returned to the facility from a hospital stay, so the facility initiated skilled nursing wound care to be completed through a home care company weekly. The home care recommended a cream and wound dressing. The nurse stated the wound care staff updated the resident's provider, assessed the wounds, and updated her of any changes or new care orders. The nurse stated facility staff were shown what to do with each care episode, and once the wound opened, the wound care company did not change the treatment but increased the frequency of it. The nurse stated the wound was healed at the facility, so the wound care company had to discontinue their services. The nurse stated the wound had re-opened during the resident's last hospital stay prior to discharge to a nursing home. The nurse stated she had spoken to the resident's family member about the resident's decline, and her medical opinion on the resident needing a higher level of care. The nurse stated the family member insisted she wanted to keep resident at the facility and begged them to keep the resident there even though the nurse knew she needed a higher

level of care. The nurse stated the resident became very hard to care for, and it was not until the resident's care manager told the family member the resident needed a higher level of care that the family member finally agreed.

During an interview, the resident's medical provider stated the resident's medical issues that affected her health the most were her dementia, chronic pain, and neuropathy. The provider stated the resident developed a pressure ulcer towards the end of her life. The resident's diabetes, failing health, poor appetite, failure to thrive and general health decline all contributed to the development of the wound. The medical provider stated when she visited the resident at the facility, she never saw anything that indicated the resident was neglected, or that her wound care was not completed properly. The medical provider stated she spoke to the resident's family member for approximately 30 to 45 minutes after each visit to discuss the resident's condition and goals for care, including her need for hospice. The medical provider stated she believed the facility was an appropriate care setting for the resident, up until the end of the resident's life when she recommended, in agreement with the facility, the resident needed a higher level of care. The provider stated she felt she was getting push back about placing the resident in a nursing home, though she could not gauge exactly where the pushback had originated from. The provider stated she had no concerns about the facility, and the staff always communicated well with her.

During an interview, a family member stated the resident was alert, oriented, and walking on her own upon admission to the facility. The family member stated the resident was mostly compliant with her care but would refuse sometimes too. The family member stated the resident did not have any skin concerns when she moved to the facility. The family member stated six months after two housemates who the resident enjoyed had moved out, she noticed a decline in the resident. The resident was not really walking, did not know the family members' name, had high blood sugars and was sent to the hospital. The family member stated the doctor told her the resident had bed sores, and she had not been previously told about them. The family member stated she was not sure why the doctor did not document the bed sores in his notes at the hospital. The family member stated she had never spoken to the resident's medical provider about the resident's skin or her concerns, and the facility never told her about the bed sores. The family member stated she had video footage of the resident left in her wheelchair in her room for long periods of time but could not retrieve it.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

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

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility facilitated wound care services, provided wound care when required and provided services to the resident as the resident allowed.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39662	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/30/2026
NAME OF PROVIDER OR SUPPLIER ANCHOR CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8443 81ST STREET SOUTH COTTAGE GROVE, MN 55016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments On July 30, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL396621169C/#HL396622824M. No correction orders are issued.	0 000			

Minnesota Department of Health

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

TITLE

(X6) DATE