Protecting, Maintaining and Improving the Health of All Minnesotans

The e

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL408631542M **Date Concluded:** May 7, 2025
Compliance #: HL408632443C

Name, Address, and County of Licensee Investigated:
Anchor Care Services
8425 69th Street S.
Cottage Grove, MN 55016
Washington County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele Larson, 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 neglected the resident when they failed to provide adequate supervision to ensure the safety and wellbeing of a resident. The resident eloped from an unlocked front door while unlicensed staff were in the lower level of the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff followed the resident's plan of care at the time the resident eloped. The resident's elopement was an isolated incident. Staff immediately called 911 when they realized the resident eloped. Law enforcement found the resident unharmed shortly after the resident left the facility.

The investigator conducted interviews with facility staff members, including facility leadership and unlicensed staff. The investigator contacted the resident's representative and law enforcement. The investigation included review of the resident's facility record, previous

facility's record, facility incident reports, personnel files, staff schedules, and facility policies and procedures. The investigator took photos of the padlocked exit doors. Also, the investigator observed the resident and direct cares during the onsite visit at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included mild cognitive impairment. The resident's service plan included assistance with all activities of daily living. The resident enjoyed walks outside with staff supervision. The resident was not fully oriented to place or time and at risk for elopement. The resident walked independently.

A progress note indicated one spring mid-afternoon the resident displayed agitation all day and refused unlicensed staff's attempts to redirect the resident to her room, choosing instead to sit in the living room while unlicensed staff went downstairs to prepare medications. When staff returned to the main level they noticed the front exit door wide open, and the resident missing.

A progress note completed by leadership, indicated law enforcement found the resident at an undetermined time at a park. The resident told law enforcement she wanted to go for a walk. Leadership told unlicensed staff the importance of always having one staff person remain on the main level to monitor the residents while the other unlicensed staff was downstairs.

The law enforcement report indicated unlicensed staff told law enforcement they normally padlocked the front exit door whenever both staff needed to be in the lower level, but stated for unknown reason, that day, the front door was not secured. Law enforcement estimated the resident went missing for approximately 40 minutes.

During an interview, unlicensed personnel stated the resident was unable to do anything for herself and was not good at communicating her needs. Unlicensed personnel stated the resident was a fast walker and the resident's elopement "happened so fast," stating the resident eloped because the previous shift most likely did not completely close the front door.

During an interview, leadership stated the resident lived at the facility for about five months. Leadership stated two staff were working the day the resident eloped. One staff was new to the position and was observing and assisting the second staff. Leadership stated both staff left the main level of the facility to set up medications, leaving the main floor unsupervised. For some reason, the door to the outside was unlocked and the resident exited the building. Leadership stated staff responded quickly and contacted 911. Leadership stated staff were educated about always securing the outside door when not able to observe the residents.

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. Unable to interview due to her cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility called 911 when they realized the resident eloped.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40863	A. BUILDING: _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE SERVICES LLC	8425 69TH 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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL408632443C#/HL408631542M On April 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL408632443C#/HL408631542M. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	