Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307623206M
Compliance #: HL307622338C

Date Concluded: October 12, 2026

Name, Address, and County of Licensee Investigated:
Wellstead Senior Living
20500 South Diamond Lake Road
Rogers, MN 55374
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Ann Boutwell, 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:
The facility neglected the resident when resident was sent to hospital with an unexplained hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident sustained a fracture, there was not a preponderance of evidence the incident was caused by a failure of facility staff to provide necessary care or services.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted family members. The investigation included review of the resident records, death record, hospital records, home health agency records, facility internal investigation, facility incident reports, related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnosis included dementia, diabetes, obesity and polyosteoarthritis (degeneration of cartilage and the underlying bone within a joint). The resident's service plan included transfers, escorts, fall monitoring and safety checks. The resident's assessment indicated resident was non-ambulatory, used a wheelchair and had severe cognitive impairment. In addition, the resident received home health services for physical therapy and nursing to maintain an indwelling catheter.

Resident records indicated the resident was seen by her primary care provider for a change of condition for poor oral intake, lethargy and generalized weakness. The primary care provider notes indicated the resident was leaning to the right, resisted repositioning, however resident had equal bilateral strength. Family was made aware of the change in condition and requested the resident remain in the facility. The following day, the resident had a fever, elevated heart rate and was minimally responsive. Emergency medical services arrived and transported the resident to the hospital.

Hospital records indicated sepsis possibly due to urinary tract infection and was started on antibiotics. The hospital admission history and physical indicated skin color was normal and there were no important skin lesions. Two days later a CT (computed tomography imaging) completed of chest, abdomen and pelvis and found an incidental finding of a right hip fracture, which may have been months old. An x-ray was performed and confirmed the right hip fracture and osteopenia (low bone mass).

An internal investigation was completed by the facility. Unlicensed personnel were interviewed following the finding of the hip fracture. Unlicensed personnel indicated that the morning the resident was sent into the hospital, the resident was found lying on the edge of the bed and had one foot on the floor. Staff reported the resident was awake, placed the resident's leg back on the bed, and due to falls risk, proceeded with cares and used an E-Z stand (medical equipment used to help people rise to a standing position) to transfer the resident to a chair. The investigation indicated no falls occurred prior to the finding of the hip fracture.

During an interview, nurse leadership stated when the hospital updated the facility of the right hip fracture, an internal investigation was completed immediately. During investigative interviews, ULP's indicated a fall did not take place, however, the resident was found in bed with one leg hanging out of the bed.

During interviews with family members, the family had no concern with cares the resident received at the facility and communication with staff seemed fine. Family stated the resident was declining since being admitted to the facility. Staff notified the family with change in conditions and family could always get a hold of someone if there were questions. Family stated the last known fall was four months ago. Family stated the doctor at the hospital told them the broken hip probably didn't happen in the days before the hospitalization but could not tell if it happened six months ago or when it happened.

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, resident deceased.
Family/Responsible Party interviewed: Yes, family members.
Alleged interviewed: Not Applicable.

Action taken by facility:
Resident was sent to emergency room for evaluation, and an internal investigation was completed.

Action taken by the Minnesota Department of Health:
No actions 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
	30762	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSTEAD SENIOR LIVING	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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 August 24, 2026, the Minnesota Department of Health initiated an investigation of maltreatment/complaint # HL3076232306M/HL307622338C. No correction orders are issued.	0 000		