Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307623386M
Compliance #: HL307622746C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Diamond Crest
20500 Diamond Lake Rd S
Rogers, MN 55374
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) neglected the resident when the resident experienced a change in condition, and the AP did not respond to a request by unlicensed staff to assess the resident. The resident was found deceased.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Unlicensed staff checked the resident's oxygen level and communicated to the AP the oxygen level was below a designated parameter. The AP instructed unlicensed staff to recheck the oxygen level with a different oximeter (device reads oxygen levels) and update the AP. The AP was in a facility staff meeting at shift change when the initial oxygen reading was reported, and the AP did not receive a call back. A short time later when afternoon unlicensed staff entered the resident's room, the resident was found unresponsive, and the AP was summoned. Progress notes, an incident report and staff interviews conducted during the investigation provided contradictory

information. It could not be determined if information about a low blood pressure reading was provided to the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, law enforcement records, rounding physician records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct cares to facility residents.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and heart attack. The resident's service plan included medication administration, assistance with activities of daily living, ambulation, and assistance of two staff for transfers with a mechanical lift. The resident's assessment indicated the resident had short-term memory loss, anxiety and behaviors, however, could effectively communicate needs and use a call pendant.

The resident record indicated unlicensed staff checked the resident's vital signs before shift change and reported a low oxygen reading to the AP. The AP instructed unlicensed staff to recheck the oxygen level with a different oximeter and report back to the AP. After shift change an unlicensed staff went to the resident's room to administer medication and the resident did not respond to knocks on the door. Unlicensed staff entered the apartment and observed the resident unresponsive. Unlicensed staff went to the AP's office down the hall, summoned assistance, and called 911.

Progress notes indicated the resident was observed doing well one-half hour before shift change. However, according to interviews and an incident report, unlicensed staff reported the resident's oxygen was low during that time and unlicensed staff were unable to obtain a blood pressure reading.

An incident report indicated unlicensed staff notified the AP by walkie talkie the resident had low oxygen levels, however, did not include information about a blood pressure reading. The AP directed unlicensed staff to recheck oxygen levels and update the AP if abnormal. The incident report indicated unlicensed staff did not report back to the AP. A short time later unlicensed staff entered the resident's room, and the resident was unresponsive. The incident report indicated the AP was summoned by unlicensed staff who had recently arrived for the second shift.

The Provider Orders for Life-Sustaining Treatment (POLST) indicated the resident chose do not resuscitate (DNR) in the event of a medical emergency.

The death record indicated the resident passed away from natural causes.

During an interview, an unlicensed staff stated there were no concerns when the resident took his morning medications. Unlicensed staff stated the resident chose to remain in his room and preferred not to be bothered. Unlicensed staff stated low oxygen levels were reported to the AP over the walkie talkie and unlicensed staff thought the AP stated she would check on him, however, was unsure exactly what was said. Unlicensed staff stated an all-staff meeting was scheduled around shift change time and during the staff meeting sirens were heard. Unlicensed staff stated she was unsure if the AP had checked on the resident when vital signs were initially reported over the walkie talkie, however, the resident could request assistance with his call pendant.

During an interview, licensed staff stated unlicensed staff document progress notes however unlicensed staff from the morning shift had not documented a progress note detailing the resident's incident. Licensed staff stated she was with the AP when unlicensed staff initially reported low oxygen, and the AP instructed unlicensed staff to elevate the head of the bed and to retake the oxygen level. Unlicensed staff were directed to call back if the oxygen level did not go up. Unlicensed staff did not call back, however, a short time later the AP was heard requesting 911 assistance for the resident over the walkie talkie.

During an interview, the AP stated during an all staff meeting an unlicensed staff reported over the walkie talkie the resident's oxygen was low. The AP directed the oxygen level be rechecked with a new oximeter and report back if the oxygen was still low. The AP stated she did not receive a call back. A short time after shift change an unlicensed staff came to her office and reported the resident was unresponsive and 911 was called.

During an interview, a family member stated the resident refused most medications, was not eating much and had experienced severe depression since the loss of his spouse several years prior. A family member stated the resident was in "really bad physical shape" when family visited several weeks before the resident was found deceased. The AP notified family when the resident passed.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility summoned emergency assistance for the resident.

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
	30762	A. BUILDING: _____ B. WING _____	C 05/19/2026

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 May 19, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307623386M/#HL307622746C. No correction orders are issued.	0 000	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	