Electronically Delivered

April 2, 2026

Licensee
The Wellstead of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Project Number(s) SL30762016

Dear Licensee:

On October 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 29, 2025

Licensee
The Wellstead Of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Project Number(s) SL30762016

Dear Licensee:

On July 18, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 23, 2025, found not corrected at the time of the July 18, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 18, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Ben Zwart at 651-201-3715.

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.

Sincerely,

Benjamin Zwart

Ben Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

CLN

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 _____	R 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	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 ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30762016-3 On July 9, 2025, through July 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 16, 2025. At the time of the survey, there were 44 residents; 44 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (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; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	{0 480}		

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{0 480}	Continued From page 1 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (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; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	

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{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	{0 680}		

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{0 680}	Continued From page 3 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (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. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.	{0 775}		

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{0 775}	Continued From page 4 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). Findings include: On a facility tour on April 15, 2025, from 1:45 p.m. to 2:15 p.m., with facility director (FD)-C, and licensed assisted living director (LALD)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CONTROLLED EGRESS DOOR LOCKS There were marked exit paths and exit doors requiring occupants to travel through two controlled egress doors (doors requiring keypad code to open) in a series leading out of Robins Ridge, Cardinal Crest wings, from Chickadee into Bluebird wings and other locations in the building, before entering the exit (exit door leading directly to the exterior and public way). During the tour FD-C, and LALD-D, stated a contractor was scheduled to complete the required alterations to the magnetic door locking systems. There were marked exit doors with controlled egress leading to the exterior from the townhall community room to a courtyard requiring occupants to travel through a second controlled	{0 775}		

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{0 775}	Continued From page 5 egress door before entering the exit. During the tour FD-C, and LALD-A, stated the local fire marshal approved the removal of the exit signs. During the survey it was observed the existing exit signs were covered with a paper sign indicating "Not an Exit". During the tour documentation was requested from the local fire marshal approving removal of the exit signs. Controlled egress door locking systems shall only require occupants to travel through one controlled egress door before entering the exit. The controlled egress door locking systems did not have an emergency release button installed in each locked area in a location constantly attended by staff. The emergency release button is required to release all controlled egress doors in order for occupants to exit in the event of a fire or similar emergency. During the tour FD-C, and LALD-D, stated a contractor was scheduled to complete the required alterations to the magnetic door locking systems. On July 9, 2025, at 1:38 p.m., documentation indicating the controlled egress door locking systems in each locked unit were provided with an emergency release switch installed in accordance with MSFC in Minnesota Rules Chapter 7511 was requested by email to LALD-A. No further information was provided. On July 17, 2025, at 10:30 a.m., documentation indicating the controlled egress door locking systems in each locked unit were provided with an emergency release switch installed in	{0 775}		

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{0 775}	Continued From page 6 accordance with MSFC in Minnesota Rules Chapter 7511 was again requested by email to LALD-A. On July 18, 2025, at 11:57 a.m., LALD-A, responded by email indicating an engineering group had toured the building to investigate and create a plan for the installation of the emergency release switches. LALD-A, also stated in the same email that they would keep me up to date when they know more. No further information was provided.	{0 775}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the	{01060}		

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{01060}	Continued From page 7 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.	

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{01540} SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01540}	Not reviewed during this survey.	

Electronically Delivered

May 21, 2025

Licensee
The Wellstead of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Project Number(s) SL30762016

Dear Licensee:

On April 16, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 23, 2025, found not corrected at the time of the April 16, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 16, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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We urge you to review these orders carefully. If you have questions, please contact Ben Zwart at 651-201-3715.

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Sincerely,

Ben Zwart, Supervisor
State Evaluation Team
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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
{0 480}	Continued From page 1 Rules, part 4626.1565 or 4626.1570; (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; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records	{0 650}		

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 _____	R 04/16/2025

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{0 650}	Continued From page 2 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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	{0 680}		

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{0 680}	Continued From page 3 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (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. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 775}		

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{0 775}	Continued From page 4 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). Findings include: On a facility tour on April 15, 2025, from 1:45 p.m. to 2:15 p.m., with facility director (FD)-C, and licensed assisted living director (LALD)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CONTROLLED EGRESS DOOR LOCKS There were marked exit paths and exit doors requiring occupants to travel through two controlled egress doors (doors requiring keypad code to open) in a series leading out of Robins Ridge, Cardinal Crest wings, from Chickadee into Bluebird wings and other locations in the building, before entering the exit (exit door leading directly to the exterior and public way). During the tour FD-C, and LALD-D, stated a contractor was scheduled to complete the required alterations to the magnetic door locking systems. There were marked exit doors with controlled egress leading to the exterior from the townhall community room to a courtyard requiring occupants to travel through a second controlled egress door before entering the exit. During the tour FD-C, and LALD-A, stated the local fire marshal approved the removal of the exit signs. During the survey it was observed the existing exit signs were covered with a paper sign	{0 775}		

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{0 775}	Continued From page 5 indicating "Not an Exit". During the tour documentation was requested from the local fire marshal approving removal of the exit signs. Controlled egress door locking systems shall only require occupants to travel through one controlled egress door before entering the exit. The controlled egress door locking systems did not have an emergency release button installed in each locked area in a location constantly attended by staff. The emergency release button is required to release all controlled egress doors in order for occupants to exit in the event of a fire or similar emergency. During the tour FD-C, and LALD-D, stated a contractor was scheduled to complete the required alterations to the magnetic door locking systems. CARBON MONOXIDE DETECTION There was single station carbon monoxide alarms installed in the boiler room and limited locations in the corridors. The carbon monoxide alarms were not installed within 10 feet of all sleeping rooms or tied into the building fire alarm system. During the tour FD-C, and LALD-A, stated a contractor was scheduled to install carbon monoxide detectors tied into the fire alarm system as required. Carbon monoxide alarms are required to be installed within 10 feet of all sleeping rooms or tied to the building fire alarm system in accordance with the MSFC in Minnesota Rules Chapter 7511. During the facility tour FD-C, and LALD-A, verified	{0 775}		

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{0 775}	Continued From page 6 the above listed observations while accompanying on the tour.	{0 775}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.	
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	{01060}		

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{01060}	Continued From page 7 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.	
{01540} SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	{01540}		

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{01540}	Continued From page 8 employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01540}	Not reviewed during this survey.	

Electronically Delivered

March 3, 2025

Licensee
The Wellstead Of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374

RE: Project Number(s) SL30762016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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. INITIAL COMMENTS: SL30762016-0 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 44 residents, all of whom were receiving services under the provider's Assisted Living with Dementia Care license.	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 with Dementia Care License Providers. 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 surveyors' 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (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; (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; (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; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-F). 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 an isolated scope (when one or a	0 650		

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0 650	Continued From page 4 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a hire date of June 15, 2023, and provided direct care services to residents of the facility. ULP-F's employee record included an "Annual Review Individual Contributors" dated September 14, 2023. ULP-F's employee record lacked documentation of annual performance reviews thereafter, that would have identified areas of improvement needed and training needs. On January 23, 2025, at 11:32 a.m., licensed assisted living director (LALD)-A stated ULP-F's record lacked any performance reviews after the performance review dated September 14, 2023. LALD-A further stated they were unable to locate any further documentation of an annual performance review due to moving offices, and not having the chance to organize employee files within the new location. The licensee's Orientation, Training, Evaluation, and Supervision of Unlicensed Personnel policy dated February 10, 2023, indicated, "The Director of Resident Care is responsible for completing a performance review of each team member providing assisted living services based on the documentation of the supervisor's observations and other relevant information. Performance reviews will be conducted annually at a minimum." No further information was provided.	0 650		

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	30762	A. BUILDING: _____ B. WING _____	01/23/2025

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0 650	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (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. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency disaster plan with all required content. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 6 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). The findings include: The licensee's Emergency Preparedness (EP) plan lacked the following required content: - development of policies/procedures to address: - names/contact information: for staff, entities providing services under agreement, residents' physicians, and other facilities, - providing care/treatment at alternate are sites under 1135 waiver; - communication plan contact information for the following: - Federal, State, tribal, regional & local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; and - Other sources of assistance. On January 21, 2025, at 2:34 p.m., licensed assisted living director (LALD)-A stated the EP binder lacked the information noted above. LALD-A stated he had been working on the EP binder with facilities director of maintenance (FD)-C to ensure the required content was present; however, was unaware that some of the required information had been missing from the EP binder. The licensee's Emergency Management Plan policy dated July 2017, indicated the EP Program	0 680		

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0 680	Continued From page 7 was developed using an all-hazards approach to comply with all applicable federal, state, and local emergency preparedness requirements. Furthermore, the Emergency Operations Plan (EOP) and its components are the master operations documents for the campus in responding to all emergencies, and all catastrophic, major, and minor disasters. The plan defines the responsibilities of all levels of management that make up the facility Healthcare Incident Command Team. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. 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).	0 775		

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0 775	Continued From page 8 Findings include: On a facility tour on January 22, 2025, from 11:00 a.m. to 2:15 p.m., with facility director (FD)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CONTROLLED EGRESS DOOR LOCKS There were marked exit paths and exit doors requiring occupants to travel through two controlled egress doors (doors requiring keypad code to open) in a series leading out of Robins Ridge, Cardinal Crest wings, from Chickadee into Bluebird wings and other locations in the building, before entering the exit (exit door leading directly to the exterior and public way). There were marked exit doors with controlled egress leading to the exterior from the Townhall community room to a courtyard requiring occupants to travel through a second controlled egress door before entering the exit. Controlled egress door locking systems shall only require occupants to travel through one controlled egress door before entering the exit. The controlled egress door locking systems did not have an emergency release button installed in each locked area in a location constantly attended by staff. The emergency release button is required to release all controlled egress doors in order for occupants to exit in the event of a fire or similar emergency. CARBON MONOXIDE DETECTION	0 775		

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0 775	Continued From page 9 There were single station carbon monoxide alarms installed in the boiler room and limited locations in the corridors. The carbon monoxide alarms were not installed within 10 feet of all sleeping rooms or tied into the building fire alarm system. Carbon monoxide alarms are required to be installed within 10 feet of all sleeping rooms or tied to the building fire alarm system in accordance with the MSFC in Minnesota Rules Chapter 7511. FIRE-RESISTANT RATED DOORS The existing fire-resistant rated doors leading out of resident sleeping room D-107, F-101, commercial kitchen door in the basement near breakroom, and several other doors to the corridor automatic closers were removed. The existing fire-resistant rated door to the stairway in the basement near the break room, and in the corridor leading from Townhall to Cardinal Crest were held open with a devices that were not tied into the building fire alarm system to automatically close the doors upon activation of the alarm. Existing fire-resistant rated doors are required to automatically close, and latch as designed and installed at the time of construction. COMPRESSED GAS CYLINDER STORAGE There were carbon dioxide cylinders stored in the corridor in the basement and the cylinders were not secured in the upright position to prevent tipping.	0 775		

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0 775	Continued From page 10 Egress corridors shall not be used for storage of compressed gas cylinders and the cylinders shall be secured in the upright position to prevent tipping in accordance with MSFC in Minnesota Rules Chapter 7511. EXTERIOR LOCKED GATES There were marked exit doors leading outside to a courtyard with gates locked with padlocks from the Chickadee and Bluebird wings. The exterior exit paths were also not maintained free of snow that was an obstruction of egress leading to the public way. Exterior gates that are part of the exit path leading to the public way are required to operate with hardware the same as the building exit doors in order for occupants to exit in the event of a fire or similar emergency. During the facility tour FD-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 11 (3) fire protection procedures necessary for residents; and (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. (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. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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. (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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	0 810		

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0 810	Continued From page 12 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, at 10:10 a.m., licensed assisted living director (LALD)-A, and facility director (FD)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on January 22, 2025, at 10:20 a.m., LALD-A, and FD-C, stated procedures for residents to take in the event of a fire or similar emergency and resident evacuation status/ unique needs for evacuation were not provided in	0 810		

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0 810	Continued From page 13 writing and available in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the resident training was provided as required. During an interview on January 22, 2025, at 10:30 a.m., LALD-A, and FD-C, stated resident training documentation records were not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a	0 970		

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0 970	Continued From page 14 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). The findings include: R1's service plan dated October 24, 2024, indicated R1 received services including: medication management, medication administration, assistance with dressing, grooming, bathing, toileting, incontinent care, laundry, housekeeping, stand-by assistance with transfers,ambulation, and escorts. R1's record included an Assisted Living Contract, signed on October 24, 2024. R2's service plan dated June 11, 2024, indicated R2 received services including: medication management, medication administration, assistance with dressing, grooming, bathing, toileting, incontinent care, laundry, and housekeeping. R2's record included an Assisted Living Contract, signed on June 14, 2024. R3's service plan dated November 23, 2024, indicated R3 received services including: medication management, medication administration, laundry, and housekeeping, R3's record included an Assisted Living Contract, signed on November 22, 2024.	0 970		

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0 970	Continued From page 15 R1, R2, and R3's Assisted Living Contract, titled "Agreement," included the following language which indicated waivers of liability for the following: Page 11: Section E: Insurance "We will not be responsible for any damage, loss or injury to your property or visitors caused by theft, fire, water or other casualty." On January 21, 2025, at 2:43 p.m., licensed assisted living director (LALD)-A stated he was under the impression the word "The" was the only language that was required to be removed from the previous contract and proceeded to do so. In addition, LALD-A stated the licensee had a lawyer review the contract prior to sending the contract to residents and resident families for signatures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 16 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all required content during an emergency relocation for two of two residents (R1, R2). 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	01060		

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01060	Continued From page 17 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). The findings include: R1 R1's Care Plan dated October 24, 2024, indicated R1 received services including assistance with medication management, dressing, grooming, bathing, toileting, fall management, escorts, stand-by assistance with ambulation, supervision, housekeeping assistance, laundry assistance and meal set-up. R1's progress notes on January 1, 2025, indicated the licensee sent R1 to the emergency room (ER) for further evaluation, for laceration to the forehead, above the left eyebrow, which R1 sustained after loss of balance causing R1 to fall backwards onto the ground. R1's progress note dated January 1, 2025, at 12:20 p.m., indicated registered nurse (RN)-D called the hospital for an update on R1's condition, and was informed that R1 would be admitted to the hospital. R1's progress note dated January 4, 2025, at 2:15 p.m., indicated R1 returned to the facility on January 4, 2025. R2 R2's Care Plan dated June 11, 2024, indicated R2 received services including assistance with medication management, dressing, grooming, bathing, toileting, fall management, escorts, transfer assistance, supervision, housekeeping	01060		

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THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01060	Continued From page 18 assistance, laundry assistance and meal assistance. R2's progress note "Late Entry" dated November 10, 2024, indicated the licensee had sent R2 to the emergency room (ER) for further evaluation, for loss of balance, which had caused R2 to stumble and strike her head on the fireplace, located in the facility dining room. On January 22, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B indicated R2 was admitted to the hospital on November 9, 2024, and returned to the facility on November 11, 2024. R1 and R2's records lacked evidence they were provided a written notice that contained, at a minimum: - the contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 22, 2025, at 12:55 p.m., CNS-B stated the licensee was unable to locate the information listed above. CNS-B further stated she was unaware of all the required content that needed to be completed when a resident had gone to the hospital; therefore, the only notification of R1 and R2's hospitalizations was to	01060		

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 _____	01/23/2025

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

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01060	Continued From page 19 their primary physician's and their responsible parties. Licensee's blank "Notification of Emergency Relocation" procedure, undated, indicated licensee would complete the following: - the contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. Furthermore, the facility would provide contact information for the agency to which the resident may submit an appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01540		

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 _____	01/23/2025

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

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01540	Continued From page 20 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed eight (8) hours of required dementia care training within 80 hours of start date for two of three employees (registered nurse (RN)-D and unlicensed personnel (ULP)-F). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee had an Assisted Living Facility with Dementia Care (ALFDC) license effective October 1, 2022, through September 1, 2025. RN-D RN-D was hired May 25, 2023, and provided direct care services to residents of the facility. RN-D's training and orientation records indicated 0.5 hours of dementia care training on the topic of	01540		

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 _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	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
01540	Continued From page 21 Dementia Care: Normal Aging vs. Alzheimer's/Dementia, completed May 26, 2023. RN-D's record lacked evidence of any further initial dementia care education. ULP-F ULP-F had a hire date of June 15, 2023, and provided direct care services to residents of the facility. ULP-F's training and orientation records indicated 0.5 hours of dementia care training on the topic of Dementia Care: Normal Aging vs. Alzheimer's/Dementia, completed June 19, 2023. ULP-F's record lacked evidence of any further initial dementia care education. RN-D and ULP-F's employee records lacked at least eight hours of initial dementia care training to include the following required topics, within 80 working hours of the employment start date: (1) assistance with activities of daily living; (2) problem solving with challenging behaviors; (3) communication skills; and (4) person-centered planning and service delivery. On January 23, 2025, at 11:32 a.m., licensed assisted living director (LALD)-A stated it was ultimately his responsibility to ensure the required training was completed and licensee was currently working with their corporate team to get caught up. The licensee's undated Orientation to Dementia Care for Assisted Living Team Members policy indicated assisted living direct-care employees would complete initial training within 80 working hours of the employment start date and would include the following topics:	01540		

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 _____	01/23/2025

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01540	Continued From page 22 (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and 5) person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *01/22/25*
Time: 15:00:00
Report: 8087251009

Food and Beverage Establishment Inspection Report

Location:

The Wellstead Of Rogers
20600 South Diamond Lake Road
Rogers, MN55374
Hennepin County, 27

Establishment Info:

ID #: 0039404
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634281981
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

MAIN KITCHEN ICE MACHINE OBSERVED WITH BUILD-UP OF PINK SLIME/MOLD OR A MOLD/SLIME LIKE MATERIAL. CLEAN WITH A FREQUENCY NEEDED TO PREVENT GROWTH. ICE MACHINE CLEANED BY STAFF. CORRECTED ON SITE.

Corrected on Site

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

MAIN KITCHEN PREP SINK OBSERVED WITH A LEAKING FAUCET. MAINTAIN THE PLUMBING SYSTEM AS DESCRIBED IN THE ABOVE RULE TO COMPLY. MAINTENANCE REPAIRED PREP SINK FAUCET. CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 158 Degrees Fahrenheit
Location: MAIN KITCHEN DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 182 Degrees Fahrenheit
Location: MAIN KITCHEN DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 161 Degrees Fahrenheit
Location: MAIN KITCHEN DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: 3-COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -8 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: RICE
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: PORK
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 144 Degrees Fahrenheit - Location: MAIN KITCHEN HOT BOX
Violation Issued: No

Process/Item: Hot Holding: POTATO
Temperature: 151 Degrees Fahrenheit - Location: MAIN KITCHEN HOT BOX
Violation Issued: No

Type: Full
Date: *01/22/25*
Time: 15:00:00
Report: 8087251009
The Wellstead Of Rogers

Food and Beverage Establishment Inspection Report

Process/Item: Cooking: CHICKEN
Temperature: 178 Degrees Fahrenheit - Location: CONVECTION OVEN - FOR HOT HOLD
Violation Issued: No

Process/Item: Ambient Air
Temperature: 155 Degrees Fahrenheit - Location: BLUEBIRD HOT BOX
Violation Issued: No

Process/Item: Hot Holding: EGG
Temperature: 160 Degrees Fahrenheit - Location: BLUEBIRD HOT BOX
Violation Issued: No

Process/Item: Hot Holding: SAUSAGE
Temperature: 161 Degrees Fahrenheit - Location: BLUEBIRD HOT BOX
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: BLUEBIRD STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: BLUEBIRD STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: BLUEBIRD STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: CHICKADEE STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: CHICKADEE STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: ROBIN STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 34 Degrees Fahrenheit - Location: ROBIN STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 34 Degrees Fahrenheit - Location: ROBIN STAND-UP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 155 Degrees Fahrenheit - Location: ROBIN HOT BOX
Violation Issued: No

Type: Full
Date: *01/22/25*
Time: 15:00:00
Report: 8087251009
The Wellstead Of Rogers

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	2

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH CHEF MASON HUMPHRIES.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND NURSE EVALUATOR II RHONDA MAKELA.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087251009 of 01/22/25.

Certified Food Protection Manager: ASHLEY H. HACKER

Certification Number: FM95909 Expires: 10/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
COREY TREMBATH
EXECUTIVE DIRECTOR

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us