Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307451641M
Compliance #: HL307456347C

Date Concluded: May 11, 2026

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident when she charged the resident for furniture and move-in fees when he was admitted to the facility. The resident incurred a financial loss of $500.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. Residents were financially responsible for moving their belongings into the facility. The resident split the cost of a rental truck with another resident, each paying $350 of the cost. The AP originally charged the resident $100 for furniture that the facility gave to the resident. The AP was unaware the facility did not charge residents for donated furniture. The facility reimbursed the payment to the resident, so he did not incur a financial loss.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, the

facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included antisocial personality disorder, depression, lumbar spondylitis, and chronic obstructive pulmonary disease (COPD). The resident's services included assistance with activities of daily living and medication management. The resident's assessment indicated the resident displayed deficits in judgement but was not at risk for financial exploitation.

The facility internal investigation indicated the resident and a peer rented a truck to move their belongings into the facility. Each resident paid $350. The total cost of rental for the truck was $925. The residents did not have enough money to cover the full cost, so the facility paid the $225 difference for them. The AP documented that the resident gave the facility $100 for a couch, shower curtain, and other items to furnish his new apartment. The resident declined a receipt for himself.

When interviewed, a supervisor said the AP was new and was not aware the facility did not charge residents for furniture provided from their storage room. The supervisor believed the resident was not reimbursed for his payment, and the resident said he paid $200 while the AP said the resident paid $100. The supervisor said it was customary that residents paid for their own moving fees.

When interviewed, the resident said the AP told him he owed $350 for the moving truck, which the resident paid in cash. The resident said the AP also asked him for $200 for furniture they took out of storage for him. The resident said the AP did not know she was not supposed to charge for the furniture and supplies, so he was reimbursed $100.

When interviewed, the AP said the resident did not have any furniture, so facility staff found items for him from their storage area. The resident paid $100 for the furniture, which he was reimbursed when the AP learned the facility did not charge residents for items retrieved from storage. As for the moving truck, residents were expected to cover their own moving costs, which the resident shared with a peer. However, they were $200 short of the total, so the facility did pay the final $200 to make up the difference.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, the resident is his own decision-maker.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and provided refresher training to the AP.

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
	30745	A. BUILDING: _____ B. WING _____	C 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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 March 24, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307456840C/#HL307451780M and #HL307456347C/#HL307451641M. No correction orders are issued.	0 000		