DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307451780M
Compliance #: HL307456840C

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: 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) abused the resident when she pinched him in response to the resident grabbing her clothing and not letting go. The pinch resulted in the resident sustaining a skin tear.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Conflicting written and verbal accounts of the incident were provided and the AP denied pinching the resident. When the resident became agitated and grabbed her jacket, the AP said she accidentally scratched the resident's hand as she tried to loosen his grip, resulting in a skin tear.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death 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 memory care unit. The resident's diagnoses included dementia and type 2 diabetes. The resident's services included full assistance with activities of daily living, meals, and medication management. The resident's assessment indicated he was vulnerable to physical abuse due to inappropriate interactions with others and verbal/physical aggression.

The facility's internal investigation indicated the resident told the AP he wanted to go to the bathroom. As the AP changed the resident's brief, the resident began to swear and then punched the AP in the chest. The resident grabbed the AP's clothing and would not let go. The AP told him to let go of her and attempted to remove the resident's hands from her clothing. The AP said the resident was very strong and she could not remove his hands from her clothing, so she pinched the resident. The resident sustained a 2-centimeter skin tear on his right arm. The resident was unable to describe what happened.

The AP's training records indicated she received training in managing challenging behaviors in dementia care, including managing physically abusive residents.

When interviewed, a supervisor said staff reported the resident became aggressive with the AP and grabbed her shirt. The AP's initial reaction was to pinch the resident to get him to let go. The supervisor did not have further details of the interaction and said she could not determine if the AP acted appropriately or not, given the circumstances. The resident sustained a skin tear, and the AP was re-educated regarding managing aggression in residents.

When interviewed, the AP said she took the resident to the bathroom in his apartment, and when the AP helped him up to get his pants on, the resident attacked her. The AP did not know what triggered the aggressive behavior. The resident hit the AP and grabbed her hand, squeezing hard. The AP said the resident continued to punch her and she told the resident to let go. The AP tried to pull her hand back, but the resident was very strong and would not let go. As the AP continued to try to get her hand loose, the resident grabbed her jacket. The resident would not let go of the AP's jacket, and as she tried to loosen the resident's grip, the AP accidentally scratched his hand. The AP said she began to panic when another staff member walked by, heard the interaction, and notified a nurse for help. The AP said she did not pinch the resident but accidentally scratched him as she tried to loosen his grip on her jacket.

A family member declined a formal interview, as the resident had never complained about his care and the family member did not have any concerns.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, family did not feel need to interview, no concerns.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and provided refresher training to the AP regarding managing agitated behavior in residents.

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

Minnesota Department of Health

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		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE