Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307453184M
Compliance #: HL307452297C

Date Concluded: July 22, 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: Lori Pokela R.N.
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 facility neglected the resident when staff did not monitor the resident after a change in condition, then when the resident went unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was conflicting information regarding when the resident's change in condition started however staff reported the resident's change in condition to the nurse and while on the phone with a nurse the resident went unresponsive then 911 was called. While emergency personnel was present the resident's no longer had a palpable pulse and CPR was initiated until staff could provide a copy of the resident's paper POLST.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), death record, facility internal investigation, facility incident reports, personnel files, staff

schedules and related facility policy and procedures. Also, the investigator observed medication, treatment administrations, cares provided and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, congestive heart failure and atrial fibrillation. The resident's service plan included staff assistance with medication management, transfers, personal cares and safety checks completed every shift. The resident's assessment indicated the resident was not always orient had difficulty retaining or recalling information, at times reluctant to have staff assist with cares but was able to make needs known.

The resident's medical records indicated that while staff completed a scheduled safety check, the resident's family member informed staff that the resident had not been feeling well and needed to be transported to the hospital. Staff called the nurse and upon return to the resident's room found the resident to be nauseous, shaking, with difficulty breathing. While staff was on the phone with the nurse, the resident became unresponsive and staff was instructed to call 911. The nurse was on the phone with emergency personnel during the incident including when the resident died.

The resident's death records indicated the resident died from a gastrointestinal bleed as an unconfirmed consequence from a ruptured abdominal aortic aneurysm, [a dangerous balloon-like bulge that forms in the lower part of the aorta, the body's main artery.]

A facility investigation completed after the incident indicated staff checked on the resident, who was responsive but found the resident to have vomited four times. Staff then left the room to retrieve a phone to call the nurse and alert other staff. When staff returned to the resident's room staff found the resident unresponsive in his bathroom, with the resident's family member informing that the resident felt like vomiting again. The nurse instructed staff to call 911, obtain a set of vital signs and continue to monitor and update the resident's change in condition. The nurse then spoke with emergency personnel regarding the resident's POLST status.

During an interview, an unlicensed personnel who work the shift prior to the incident stated the resident did not have any change in condition and was acting normally. The unlicensed personnel stated the resident's family member was in the room and stated the family did not mention any concerns regarding the resident at that time.

During an interview, an unlicensed personnel who was working at the time of the incident stated when she arrived in the resident's room, the resident's family member informed the resident should be transported to the hospital because he has vomited blood four times, was vomiting all day and informed by an unidentified staff that if it got worse to report. The unlicensed personnel obtained a phone to report the findings and hospital transport request. When the unlicensed personnel returned to the room the resident was in the bathroom and informed the unlicensed personnel that he needed to vomit again, then became unresponsive

with the nurse on the phone who instructed me to call 911. The unlicensed personnel stated while on the phone with 911, another unlicensed personnel to assisted to sit the resident on the toilet. The unlicensed personnel recalled the emergency personnel administering CPR to the resident for approximately five minutes until emergency personnel received a screen shot of the resident's POLST from the nurse.

During an interview, a facility nurse stated staff reported the incident to her and when emergency personnel arrived the resident still had a weakened pulse but then performed CPR on the resident. The facility nurse stated she communicated with emergency personnel regarding the resident's POLST status.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff notified the nurse after the resident had a change in condition.
Staff located the resident's electronic POLST during the incident.
Staff attempted to print the resident's POLST per emergency personnel's request.
A facility investigation of the incident was completed.
The facility revised and trained staff on the policy and procedures regarding emergencies and the resident's POLST location.

Action taken by the Minnesota Department of Health:
Give credit to the facility for what they did do, even if maltreatment occurred.

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 06/23/2026

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 June 23, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307452297C/#HL307453184M. No correction orders are issued.	0 000		