Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307458482M
Compliance #: HL307451180C

Date Concluded: February 19, 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 abused the resident when the resident returned to the facility with a wheelchair seat belt fastened and a facility management nurse/alleged perpetrator (AP), informed unlicensed staff that it was acceptable to keep the seat belt fastened as long as it was covered up with a blanket so no one would be able to view it.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP's communication was unprofessional, there was not a preponderance of evidence the incident met the definition of abuse. Facility staff and the resident's hospice nurse could not recall details of the incident, other staff involved were unavailable for interview and the seat belt was initially unfastened after the AP discovered it. Later the same day, unlicensed staff refastened the seat belt then proceeded to ask a facility staff nurse about the resident's seat belt and the facility staff nurse informed the unlicensed staff that the seat belt needed to be removed. The resident's wheelchair seat belt was permanently removed the same day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's hospice agency nursing staff. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed the facility physical plant, medication administrations, treatment administrations, cares being given to residents and staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included right fractured femur and Alzheimer's Disease. The resident's service plan included assistance with activities of daily living (ADLs), medication management, wheelchair mobility and two person assistance with a mechanical lift for transfers. The resident's assessment indicated the resident was oriented to self, had cognitive impairment, unclear speech and unable to follow directions. The resident's assessment indicated the resident was unable to make her needs known to staff and staff used verbal communication and the resident's body language to identify discomfort.

The resident's medical records indicated the resident returned to the facility after a transitional care unit (TCU) stay following a right femur fracture. The resident was transported back to the facility in a wheelchair via a transport agency. The resident returned to the facility with orders for a hospice evaluation.

Handwritten facility investigative notes indicated the resident returned to the facility in a wheelchair with the seat belt on. The facility investigative notes indicated the AP informed staff that it was fine to have the seat belt on as long as it was covered up with a blanket. This document was signed by unlicensed staff (ULP-1), (ULP-2) and (ULP-3).

Handwritten facility investigative notes that were unsigned, indicated ULP-1 informed the writer that she was unsure if the AP was joking about the seat belt comment and that ULP-1 acknowledged the facility's restraint free policy. The facility investigative notes indicated that ULP-3 informed that she did not think the AP was joking, therefore put the resident's blanket back on and did not think the comment was something to joke about. The facility investigative notes indicated the resident attempted to eat lunch, then staff unfastened the resident's seat belt and transferred her to bed. Later, when the resident was transferred back to her wheelchair and the seat belt was fastened again. The facility investigative notes indicated the resident's hospice nurse reported the resident's seat belt and informed that the resident could not have it. This document indicated an administrative and facility staff nurse were notified and the seat belt was taken off. The facility investigative notes indicated facility staff were re-educated on the facility's restraint free policy.

A facility provided email from the administrative nurse indicated the resident was unaware her wheelchair safety belt was fastened due to cognitive impairments. The email indicated a formal facility investigative interview was not able to be completed with the resident, but when facility

staff asked the resident if she was okay while the wheelchair seat belt was being removed, the resident was unable to respond appropriately. The email also indicated some of the facility investigative interviews were not able to be located as the administrative staff that had completed them were no longer employed at the facility. In this email, the administrative nurse indicated that re-education regarding the facility's policy on restraints was promptly delivered verbally with facility staff.

During an interview, the AP stated she found the resident's wheelchair seat belt fastened when she completed the resident's vitals, pulled back the resident's lap cover and observed the seat belt fastened. The AP stated she exclaimed: "Oh, she has a seat belt on!" The AP stated ULP-1 who was behind her informed the AP that the resident could not have the seat belt to which the AP responded: "Yes, that is correct." The AP stated she tried to pinch the fastened seat belt to unfasten to listed to the resident's bowel sounds but was unable to open. The AP then instructed three unlicensed staff to bring the resident to her room to lay her down. ULP-2 asked the AP if the resident's belt should be removed and the AP stated she made the poor decision to sarcastically and jokingly say something to the effect of: "If it's covered up no one will know.." The AP stated she instructed ULP-1, ULP-2, ULP-3 and a facility staff nurse to assist in laying the resident down. The AP stated the resident was brought to her room and per requests of all three unlicensed staff, the AP and facility staff nurse demonstrated how to transfer the resident to bed. The AP stated she went back to her office to complete the assessment documentation and had a handwritten note to contact facility maintenance to permanently remove the resident's wheelchair seat belt but could not complete the tasks as she had to leave the facility. The AP stated she was later asked by administrative staff including nursing administrative staff if it was appropriate to use a restraint on the chair to which the AP responded she would never say that and the AP understood restraints could not be used. The AP stated the seat belt was removed right away, other staff including nursing staff could have contacted the maintenance department to remove the seat belt and stated the comment was not made to cause any harm.

During an interview, ULP-1 stated she recalled the resident's wheelchair seat belt was fastened when the resident was returned to the facility. ULP-1 stated she recalled the fastened seat belt when the resident's vital signs were being completed. ULP-1 stated she asked the AP if the fastened seat belt was legal and the AP responded by giggling and then informed ULP-1 that the fastened seat belt was okay as long as you cover it up then laughed. ULP-1 stated after the resident's vital signs were obtained the AP instructed ULP-1 to lay the resident down. ULP-1 stated that the AP, a facility staff nurse and maybe ULP-2 and ULP-3 were present when the resident was transferred into bed but did not recall who unfastened the seat belt nor could ULP-1 recall fully if the resident was laid down, if the AP demonstrated the resident's transfer nor could ULP-1 recall any details regarding the resident being transferred back to her wheelchair. ULP-1 stated she felt like the facility removed the seat belt but could not recall who cut the seat belt off.

During an interview, a facility staff nurse recalled the resident returning to the facility with a fastened wheelchair seat belt. The facility staff nurse stated she called the resident's transitional care unit (TCU), who informed the facility staff nurse that their facility fastened the resident's seat belt for the transport back to the facility. The facility staff nurse could not recall who unfastened the resident's seat belt but stated the seat belt was unfastened right away before the resident was put to bed. The facility staff nurse stated before the resident was laid down, she informed ULP-1 that the seat belt needed to be removed. The facility staff nurse stated staff later transferred the resident back to her wheelchair and reported that they fastened the seat belt. The facility nurse stated the seat belt was removed as soon as it was reported and the resident's seat belt was not fastened for very long.

During an interview, the administrative nursing staff stated it was not uncommon to see resident's return to the facility with their wheelchair seat belts fastened. The administrative nurse stated she was at the facility when the resident's hospice nurse reported the incidents involving the resident's seat belt. The administrative nurse stated the hospice nurse was informed that the resident's seat belt was going to be removed because unlicensed staff fastened the resident's seat belt a second time after being transferred to the wheelchair after a nap. The administrative nurse stated the AP informed the administrative nurse during a facility interview, that the AP acknowledged the statement made to unlicensed staff and that is was only meant as a joke. The administrative nurse stated ULP-1 informed the administrative nurse that she (ULP-1), did not feel the AP acknowledged the concerns regarding the seat belt and proceeded to follow the AP's instruction that it was acceptable to fasten the resident's seat belt then cover it with a blanket. The administrative nurse stated she did not think to inquire with the unlicensed staff as to why they did not ask her (the administrative nurse), for clarification regarding the resident's seat belt or facility policy. The administrative nurse stated the AP was no longer employed at the facility following the incident.

In conclusion, the Minnesota Department of Health determined 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.

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, due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility administrative staff investigated the incident. The residents seatbelt was removed and the incident was reported. The facility re-educated staff regarding the use of restraint.

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 01/08/2026

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 January 8, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307451180C/#HL307458482M. No correction orders are issued.	0 000		