

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317616704M
Compliance #: HL317616083C

Date Concluded: December 10, 2025

Name, Address, and County of Licensee

Investigated:

Lino Lakes Gracewood
675 Market Place Dr
Lino Lakes, MN 55014-2454
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, after multiple falls and injuries, the facility did not develop interventions to prevent future falls.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident had multiple falls, facility staff reported, assessed, monitored, treated and developed post-fall preventative measures after each fall reviewed. The resident's providers and family were notified of each fall.

The investigator conducted interviews with facility staff members, including administrative, nursing and unlicensed staff. The investigator contacted the resident's hospice agency. The investigation included review of the resident record(s), death record, hospice records, facility incident reports, personnel files, related facility policy and procedures. Also, the investigator

observed the facility physical plant, medication administrations, treatment administrations, cares given to the residents and staff interactions.

The resident resided in assisted living memory care unit. The resident's diagnoses included Parkinson's Disease, vascular dementia, orthostatic hypotension and chronic kidney disease. The resident's service plan included daily assistance with transfers, mobility, safety checks, toileting. The resident's assessment indicated the resident was alert and orient to person only, with forgetfulness, confusion, memory loss including poor decision-making skills. The resident's assessment indicated the resident had a history of behaviors that included resistance to cares, taking medication and physical aggression. The assessment also indicated the resident had a history of falls.

The resident's medical records indicated the resident had several falls in a six-month period reviewed. Following each fall facility staff assessed the resident then report their findings to the nurse, who instructed staff on a plan to monitor and treat the resident. Subsequently, facility administrative staff completed a post-fall review for each fall then developed and initiated updated fall prevention interventions.

The resident's medical records indicated a couple of the resident's falls resulted in a head strike, but the resident's family decided not to transport the resident to the hospital for evaluation. The resident's medical records indicated facility staff assessed, monitored and treated the resident's head injury per family request.

The resident's medical records indicated the resident received hospice services during the time reviewed for the multiple falls. The resident's hospice agency provided additional assessment, monitoring, treatment and input on updated post-fall preventions.

The resident's medical records indicated the resident had a last unwitnessed fall that resulted in the resident reopening an old wound on the right eyebrow, a new skin tear on the left elbow, both of which were reported, assessed and treated. The next four days the resident's condition declined when the resident did not eat, became lethargic, had increased pain, restlessness and a slight fever. The hospice agency nurse adjusted the resident's comfort medications throughout the four days and instructed facility staff to monitor the resident's temperature every shift. The fifth day after the resident's fall, the resident died.

During an interview, an unlicensed staff stated the resident fell a lot after he would attempt to transfer by himself. The unlicensed staff recalled it being difficult to prevent the falls as the resident walked around a lot and staff could not observe the resident one hundred percent of the time.

During an interview, facility nurse #1 stated the resident's provider would be notified of any post fall abnormal assessments, including abnormal vital signs. Facility nurse #2 stated the

resident's behaviors were taken into consideration as they related to falls and staff were educated to offer as needed behavior medications as fall preventative.

During an interview, a hospice, agency, administrative, nurse, who reviewed the resident's medical records, stated there were several falls, follow-up visits provided by hospice agency nurses. The hospice, agency, administrative nurse stated assessments, treatment, medication review and post-fall intervention recommendations were routinely made at each visit.

During an interview, the resident's family members stated the resident wanted to remain independent and would attempt to transfer and ambulate by himself to the bathroom. The resident's family members stated the facility did everything they could to prevent the falls and both the facility and the resident's hospice agency effectively communicated updates regarding the resident's condition. The family members stated they believed facility staff "loved" the resident and the family members were happy with the care provided.

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. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility completed facility incident reports.

The facility reported all falls to the resident's provider, family and hospice agency.

The facility completed post-fall reviews and initiated fall prevention interventions after each fall.

The resident was assessed, monitored and treated after each fall.

The facility completed assessments after falls and changes in condition when applicable.

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: 31761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER LINO LAKES GW LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 675 MARKET PLACE DRIVE LINO LAKES, MN 55014
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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
0 000	<p>Initial Comments</p> <p>On November 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL317616083C/#HL317616704M.</p> <p>No correction orders are issued.</p>	0 000		

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