

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317617202M
Compliance #: HL317616762C

Date Concluded: January 20, 2026

Name, Address, and County of Licensee

Investigated:

Lino Lakes Gracewood
675 Market Place Drive
Lino Lakes, MN 55102
Anoka County

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

Evaluator's Name: Brandon Martfeld, RN,
BSN, 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) neglected the resident when the resident did not receive medication according to physician orders and the resident was hospitalized.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident received a different resident's medications, the error was an isolated incident and the facility provided timely care in response to the error. The resident's blood pressure and pulse decreased, and the resident was sent to the hospital. The resident required placement of a pacemaker, (a medical device that uses electrical pulses to regulate the heart's rhythm, correcting slow, fast, or irregular heartbeats by prompting the heart to contract and pump blood effectively). A physician stated the resident had a history of atrial fibrillation (an irregular heartbeat) and would have needed a pacemaker placed to ensure the heart rate was within normal range of 60 to 100 beats per minute.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the physician. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator made an unannounced visit and observed administration of medication.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, dementia, atrial fibrillation, and bradycardia sinus (a slower than normal heartbeat, resulting in a heart rate below 60 beats per minute). The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident had intact cognition and but was determined unable to safely self-administer medication because of dementia.

The resident's medical record indicated one evening the AP gave the resident another resident's medications. After realizing the resident received the wrong medications, the AP obtained the resident's vital signs. The AP called the on-call nurse and instructed to take the resident's vital signs again after 30 minutes. The resident's blood pressure and pulse decreased. The resident's blood pressure was taken a third time. The resident's blood pressure and pulse had decreased again and was no longer within normal range. The AP called emergency medical services and the resident was taken to the hospital.

Hospital records indicated the resident had a slow heart rate and medications were adjusted. The resident was hospitalized for three days and sent back to the facility. That same day the resident was sent back to the hospital because of tachy-brady syndrome (a heart rhythm disorder where the heart alternates between beating too fast and too slow). The resident had a pacemaker placed and returned to the facility after three days.

During an interview, a physician stated the resident had a history of atrial fibrillation and was on medications that slowed his heart rate down. During the medication error the resident received three medications that lowered his blood pressure, which may have affected the resident's heart rate. The physician stated the resident did not receive the pacemaker because of the wrong medications. The resident was likely going to need a pacemaker placed because of atrial fibrillation.

During an interview, the AP stated there was confusion between two residents when the error occurred. The AP identified the error as the resident swallowed the medications. The on-call nurse, leadership, and the resident were alerted of the medication error. The AP stated she never had made a medication error before.

During an interview, leadership stated the AP was educated on the medication error and was removed from administering medications. The AP would receive medication administration training if she administered medications again.

During an interview, a family member stated the facility assisted with medication administration along with other activities of daily living. The family member was notified of the medication error and stated the resident had a heart problem prior to the medication error and had been seen by a cardiologist.

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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Following the medication error, the resident’s vital signs were monitored, and the resident was sent to the hospital. The AP was educated on the medication error and the facility’s medication administration policy and was removed from medication administration.

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 01/06/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LINO LAKES GW LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 675 MARKET PLACE DRIVE 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	<p>Initial Comments</p> <p>On January 6, 2026, the Minnesota Department of Health initiated an investigation of complaint HL317617202M/HL317616762C. No correction orders are issued.</p>	0 000		

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