

# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL307452322C

**Date Concluded:** August 5, 2023

**Name, Address, and County of Facility**

**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:** Maggie Regnier, RN  
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30745</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/21/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINO LAKES ASSISTED LIVING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>725 TOWN CENTER PARKWAY</b> <b>LINO LAKES, MN 55014</b>		
(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	<b>Initial Comments</b>  On June 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307452322C; HL307452281C, HL307456565M; HL307451601C, HL307456146M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE