Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211529782M
Compliance #: HL211524301C

Date Concluded: February 26, 2026

Name, Address, and County of Licensee Investigated:
Vitality Living of Sebeka
1005 Wells Avenue West
Sebeka, MN 56477
Wadena County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
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 failed to follow the prescribed care plan.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence that neglect occurred. The resident's care was managed by outside agency hospice staff, and the plan of care was implemented by the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted both hospice providers. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, hospice records, and related facility policy and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included acute onset chronic diastolic and systolic heart failure. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was on hospice and facility staff were responsible for managing the resident's medications.

The resident resided at the facility for nine days before he passed away. The resident was admitted to hospice the day he arrived at the facility and changed hospice providers five days later. Both hospice agencies utilized by the resident were outside agencies not affiliated with the facility. Hospice staff managed the resident's care and documentation indicated hospice and facility staff assessed and monitored the resident's condition throughout his stay at the facility. Facility staff alerted hospice when changes in the resident's condition were observed.

It was alleged that the resident was administered a medication that he was allergic to; however, review of the resident's hospice records and medication administration records identified medication allergies and there was no evidence to support the resident was administered this medication. Concerns related to medication administration were identified and a state licensing order was issued related to this investigation.

During an interview, the former Registered Nurse (RN) stated she went on leave a few days after the resident was admitted to the facility, so she did not have any knowledge of concerns or issues related to the resident's care.

During an interview, the former licensed assisted living director (LALD)/RN stated she was terminated a few days after the resident admitted to the facility. The former LALD/RN stated she worked at another location owned by the licensee and was at the facility approximately one day per week. The former LALD/RN stated when the resident switched hospice providers the facility wasn't immediately notified of the change. The former LALD/RN stated if they brought concerns to the resident's power of attorney (POA), the POA would tell them to bring their concerns to the hospice provider.

During an interview, the resident's POA stated there were concerns with the resident's medications and she made several requests for the resident's records, but management never responded to her or provided the records.

During interview, unlicensed personnel (ULP) stated the resident admitted quickly to the facility and it was "pretty hectic" at that time with management changes.

During an interview, a nurse who worked for the initial hospice provider stated she reviewed a medication list with the resident's POA which included a medication the resident was allergic to; however, the hospice agency did not administer the resident's medications, and it was not something they would have administered. Hospice records indicated the resident was not administered the medication by hospice. The hospice nurse stated the POA voiced concerns about staff not being educated enough to do the job they were doing.

During an interview, a nurse who worked for the secondary hospice provider stated she knew the resident's POA tried to get the resident's records from the facility but no one got back to her and the POA felt the facility was hiding something. The hospice nurse stated they planned to complete additional education with facility staff but the resident was only under their care for a few days before he passed away.

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:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	21152	A. BUILDING: _____ B. WING _____	C 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING OF SEBEKA LLC	1005 WELLS AVENUE WEST SEBEKA, MN 56477

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL211529782M/ #HL211524301C On January 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were nine residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL211529782M/ #HL211524301C, tag identification 0900, 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900		

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0 900	Continued From page 1 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of two residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 900		

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0 900	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 27, 2026, at 9:55 a.m., licensed assisted living director (LALD)-A stated she, her boyfriend, and three, sometimes four, children lived in the lower level of the facility. LALD-A began employment as the director of record for the facility in December 2025. Contracts for all occupants of the lower level were requested. On January 27, 2026, at 12:00 p.m., LALD-A stated there were not any contracts because the lower level was not considered to be licensed space for the assisted living. Minnesota Assisted Living Statute 144G.50 Subd. 1 indicates: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 3 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered per prescriber orders for one of one residents (R1) reviewed. R1 had several doses of prescribed medications not given due to not being in stock. The facility failed to follow up on the medication errors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnoses included acute on chronic	01760		

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01760	Continued From page 4 congestive heart failure. R1 admitted to the facility on November 26, 2025, and passed away on December 4, 2025. R1's unsigned service plan indicated the resident received medication management services. R1's assessment dated November 26, 2025, indicated the resident was on hospice and that facility staff were responsible for managing the resident's medications. Medication error forms reviewed did not include any medication errors related to R1. R1's medication administration record (MAR) for November 2025 indicated the resident did not receive the following medications: -Anoro Ellipta inhaler (for shortness of breath) on November 27 was marked as not available -Zoloft 25 milligrams (mg) (an anti depressant) on November 29, November 30 were marked as out of stock, nurse notified R1's MAR for December 2025 indicated the resident did not receive the following medications: -Zoloft 25 mg on November 1 was marked as none in building -Ativan 1 mg (for anxiety) on November 1 was marked as not given as ordered at 8:00 p.m. as the resident got a PRN dose at 6:30 p.m. R1's record lacked evidence staff contacted the RN to hold the scheduled dose of Ativan. -Duo-Neb nebulizer (for shortness of breath) on November 2 marked as not in facility R1's record lacked evidence of follow up on medications that were marked as not available and were not given as ordered.	01760		

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01760	Continued From page 5 R1's progress notes indicated on November 2, 2025, R1's oxygen was noted to be 65% on 4 liters of oxygen. The RN advised staff to elevate the head of bed and administer a duo neb nebulizer. Staff called the RN back to notify her that there was no nebulizer available in the facility. The RN noted she could "hear resident grunting while breathing." R1's oxygen had increased to 93% so she advised staff to monitor and call back in 30 minutes. When calling back, staff advised the RN that oxygen was in the low 90s with labored breathing. The triage RN advised giving PRN morphine if breathing worsened. The record lacked evidence the hospice provider had been updated the ordered duo neb was not available. Three months of medication error reports were reviewed, of 14 identified errors, 6 errors were due to a medication not being in the cart or staff were unable to locate the medication in the cart. On January 29, 2026, at 10:55 a.m., former registered nurse (RN)-A stated she went on a leave of absence a few days after the resident admitted to the facility so she did not have any knowledge of concerns or issues with the resident. On January 29, 2026, at 11:15 a.m., former licensed assisted living director/registered nurse (LALD/RN)-G stated she was terminated shortly after the resident admitted to the facility and did not have any knowledge of the errors with R1's medications. The licensee's Medication Errors policy dated March 3, 2025, indicated the facility would ensure an appropriate procedure for handling,	01760		

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01760	Continued From page 6 documenting, investigating, and appropriately following up on medication errors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		