STATE LICENSING COMPLIANCE REPORT

Report #: HL345967087C

Date Concluded: July 23, 2025

Name, Address, and County of Facility Investigated:
Vitality Living of New York Mills
215 Tousley Avenue South
New York Mills, MN 56567
Otter Tail County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34596	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING OF NEW YORK MILLS LLC	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

(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: #HL345964062M/#HL345967867C #HL345967087C On June 25, 2025, 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 32 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL345967087C, tag identification 0115. The following correction orders are issued for #HL345964062M/#HL345967867C, tag identification 0620, 1760, 2360.	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.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories	0 115		

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0 115	Continued From page 1 (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to obtain an assisted living facility with dementia care license. The facility was secured, and the residents were not able to leave the building without staff assistance. This had the potential to affect all residents living at the facility. 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 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 June 25, 2025, at 9:00 a.m., the investigator entered the facility. The door was locked and a button needed to be pressed to release the doors	0 115		

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0 115	Continued From page 2 and enter. On June 25, 2025, at 9:15 a.m., licensed assisted living director in residence (LALDIR)-A confirmed a code was required to exit all doors in the facility and there were two residents who would not be able to read the code. LALDIR-A stated the facility was considered secured, not locked, because the code was available. LALDIR-A stated the facility had been purchased within the last year and the new ownership had been looking at which communities needed to change their license and their facility was considered questionable. On June 25, 2025, at 9:55 a.m., the investigator observed a door near room 315 that had a keypad near the door. The door was locked. The investigator was not able to locate where the code was written. The investigator observed a keypad by a door near a commons area.. The door was locked. The investigator was not able to locate where the code was written. The investigator observed a door near a nurses station. The door was locked. The investigator was not able to locate where the code was written and asked a maintenance staff member where the code would be. The staff person pointed out a small code written on a metal panel about three feet above the door. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	0 115		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 3 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 4 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to immediately report	0 620		

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0 620	Continued From page 5 suspected neglect after the resident received two consecutive doses Mounjaro, of a medication ordered to be given weekly. The medication was transcribed incorrectly as a daily medication. The resident developed nausea and vomiting. The resident was sent to the emergency room and diagnosed with aspiration pneumonia. Documentation from the hospital indicated it was presumed the resident's aspiration pneumonia was from the resident's vomit and she was vomiting due to a "too high initial dose" of the medication. Hospital records indicated a physician reviewed the resident's medication list that was provided from the facility. The physician noted a new medication, Mounjaro, was started on June 11, 2025, and was to be given weekly. The physician wrote, "The order on the list of medications states, however, that it's given daily. I called the facility this morning to clarify that. The nurse I spoke to checked the records and told me that the patient received one dose on 6/11/25 and one on 6/12/25, both at 5 pm. The patient started vomiting in the evening on 6/12/25..." On June 27, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-B stated she was not sure who the physician spoke with but that it was not with her. CNS-B stated staff were generally pretty good at calling the registered nurse but she had not been notified of the physician's call to clarify the administration of Mounjaro. CNS-B stated if she had been aware of the error, it would have been reported to MAARC as the resident was hospitalized. The licensee's Vulnerable Adult Maltreatment Policy dated indicated any staff person who witnessed or suspected maltreatment of a vulnerable adult would report the incident immediately to the assisted living director. Staff	0 620		

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0 620	Continued From page 6 would then complete an incident report and investigate the incident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication 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 as ordered for one of one residents (R1). A transcription error occurred, resulting in a weekly medication being given daily. After two doses, the resident began to vomit and developed aspiration pneumonia as a result. The resident was hospitalized. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01760		

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01760	Continued From page 7 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type two diabetes. R1's service plan dated November 25, 2024, indicated the resident received services including medication administration R1's assessment dated June 3, 2025, indicated the facility managed the resident's medications. R1's record contained an order dated June 10, 2025, to start Mounjaro 2.5 milligrams (mg)/0.5 milliliters (ml) once a week. The medication was used to treat type two diabetes and help lower blood sugar. The facility provided documentation which indicated registered nurse (RN)-C entered the order reading Mounjaro 2.5 mg/0.5 ml inject 0.5 ml (2.5 mg) under the skin once weekly to be given daily. R1's June 2025 medication administration record (MAR) indicated the resident was to receive Mounjaro 2.5 mg once a week on the instructions, however it showed as a daily medication in the MAR. The medication was marked as given on June 11 and June 12. R1's progress notes indicated the resident started new medications on June 11, including Mounjaro.	01760		

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01760	Continued From page 8 Progress notes indicated at 9:40 a.m. on June 13, 2025, the resident had vomited in her bed and was brought to the shower. The resident was noted to be weak, leaning over the chair, her color was pale and she had a weak pulse of 94. The resident's oxygen saturations could not be obtained but her respirations were 25 (normal is 12 to 20). The resident's son was called and she was sent to the emergency room. R1's record lacked a medication error form completed at the time of the incident. A medication error form was completed after the error was identified by the investigator. A medication error form dated June 25, 2025, indicated Mounjaro was transcribed incorrectly by RN-C on June 11, 2025, resulting in the medication being transcribed as daily instead of weekly. The initial dose was given at 5 p.m. on June 11 and another dose was given at 5 p.m. on June 12. It was noted the resident received the second dose in error on June 12 due to a transcription error. Hospital records indicated a physician reviewed the resident's medication list that was provided from the facility. The physician noted a new medication, Mounjaro, was started on June 11, 2025, and was to be given weekly. The physician wrote, "The order on the list of medications states, however, that it's given daily. I called the facility this morning to clarify that. The nurse I spoke to checked the records and told me that the patient received one dose on 6/11/25 and one on 6/12/25, both at 5 pm. The patient started vomiting in the evening on 6/12/25..." The resident admitted to the hospital with severe sepsis secondary to aspiration pneumonia. The resident also had acute renal (kidney) failure due	01760		

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01760	Continued From page 9 to volume depletion from vomiting. The "nausea and vomiting very likely triggered by too high initial doses of Tirzapatide [Mounjaro]." The physician discussed treatment options with the resident's son and that the resident may not survive. Discharge instructions for the resident read, "You were admitted to the hospital because you had severe nausea and vomiting after starting Mounjaro and we think you may have aspirated with this. You were treated for sepsis, aspiration pneumonia, and then went into full kidney failure. We thought you would like die and you and your family decided to move toward comfort measures; however, you rallied and your kidneys started working again which was a big surprise. You did really well after that and didn't have any more symptoms of infection or illness..." After seven days in the hospital, the resident discharged to a transitional care unit. On June 25, 2025, at 9:10 a.m., licensed assisted living director in residence (LALDIR)-A stated she was not aware of any medication errors that resulted in the resident's hospitalization. On June 25, 2025, at 9:15 a.m., clinical nurse supervisor (CNS)-B stated the resident had aspiration pneumonia and she was not aware of any medication errors. CNS-B stated she was not aware of the resident getting multiple doses of Mounjaro and thought she had only received one dose. On June 26, 2025, at 11:35 a.m., the resident's son stated he had thought the resident was going to die and for a while she was not doing well at all. The resident's son stated he was initially not	01760		

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01760	Continued From page 10 aware of a medication error until the hospital had informed him of it. The resident's son stated no one from the facility followed up with him about it or said anything about it. The resident's son stated the resident started a new medication on June 11th and was only supposed to get it once a week but was given it again the next day and shortly after she began to vomit. The resident's son stated the resident threw up in her bed and got some vomit in her lungs and ended up getting dehydrated. The resident's son stated the facility called him the next morning to tell him she had thrown up a few times and if he wanted her to be sent in, which he told the facility he would want her brought in for evaluation. The resident's son stated it was a "roller coaster ride" where they were planning funeral services before the resident made an unexpected recovery. On June 27, 2025, at 12:10 p.m., unlicensed personnel (ULP)-F stated she had given the resident the second dose of Mounjaro and as she could recall, the resident didn't get it very often but she wasn't aware of when the last dose was given and that unless you looked for it in the medical record, it wouldn't show when the last dose was given. ULP-F stated that evening, the resident began to vomit but she wasn't sure if the on-call nurse was notified as they thought she just had a stomach bug. On June 27, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-B stated when the order for Mounjaro first came through, the pharmacy had advised it needed a prior authorization so she did not add it to the MAR as she figured the prior authorization would take a few days. CNS-B stated a corporate nurse who floated to the facility to provide temporary support until a case manager could be hired had added it to the MAR	01760		

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01760	Continued From page 11 after the prior authorization went through that day. CNS-B stated the facility MAR interfaces with the pharmacy and the pharmacy would have it show as daily so the facility could pick which day of the week they wanted a weekly medication to be given. CNS-B stated the other nurse didn't notice this and so the medication was inadvertently entered as a daily medication. CNS-B stated she was reconciling the resident's medications after she was notified of the error and confirmed that two doses had been given. On June 27, 2025, at 1:20 p.m., ULP-H stated she worked on June 12th and she was going to get the resident ready for bed and someone told her she threw up. ULP-H stated she helped clean the resident up around 7:30 or 8:00 p.m. and she was told by other staff that the resident had been throwing up and the nurse was already aware. On July 1, 2025, at 10:45 a.m., registered nurse (RN)-K stated she worked for a company that provided phone triage support for the facility and was called on June 14, 2025, by a ULP who had only asked that the resident be placed on hold as she was in the hospital. RN-K stated she could not recall being told anything about a physician calling or that there was a possible medication error and if she was made aware of an error or that a physician wanted to speak with her, she would have notified the facility and documented it. On July 1, 2025, at 2:00 p.m., RN-C stated she had not been aware of the error until it was identified by the investigator. RN-C stated from what she could gather after visiting with her supervisor was that when she was pushing the order through from the pharmacy connect software, she did not change it from daily to weekly. RN-C stated medications default to daily	01760		

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01760	Continued From page 12 in the software so the facility would have to change it to what had been ordered. RN-C stated she only periodically worked at the facility to provide nursing support and was not involved with her hospitalization. On July 2, 2025, at 3:25 p.m., ULP-I stated the hospital had called her on the 14th and requested a medication list so she contacted RN-K and did not know what happened from there. The licensee's Medication Errors policy dated March 3, 2025, indicated the facility would ensure an appropriate procedure for handling, documenting, investigating, and appropriately following up on medication errors. The licensee's Medication & Treatment Orders: Receiving, Renewal, Implementation, and Reordering policy dated November 29, 2024, indicated medication orders would be implemented within 24 hours of receipt. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.	02360	No plan of correction required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34596	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING OF NEW YORK MILLS LLC	215 TOUSLEY AVENUE SOUTH NEW YORK MILLS, MN 56567

(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
02360	Continued From page 13 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		