Electronically Delivered

March 26, 2024

Licensee
Vergas Assisted Living
405 East Frazee Avenue
Vergas, MN 56587

RE: Project Number(s) SL20135015

Dear Licensee:

On March 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 4, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Electronically Delivered

January 19, 2024

Licensee
Vergas Assisted Living
405 East Frazee Avenue
Vergas, MN 56587

RE: Project Number(s) SL20135015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each

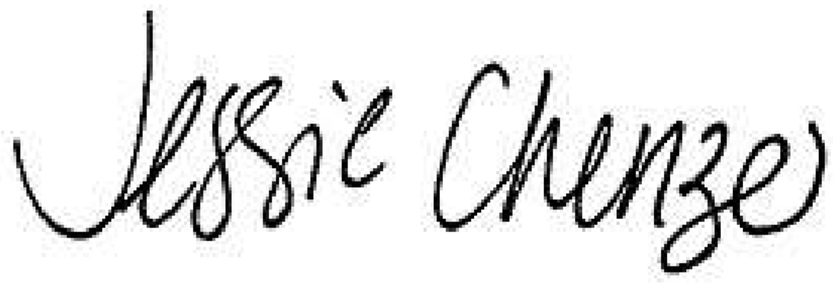
matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#20135015 On January 2, 2024, through January 4, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 15 residents receiving services under the Assisted Living license. An immediate correction order was identified on January 3, 2024, issued for SL#20135015, tag identification 1290. On January 3, 2024, the immediacy of correction order 1290 was removed, however noncompliance remained at a scope and level of I.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was evaluated at least twice a year of the appropriateness of the staffing levels in the facility as required. This had the potential to affect all residents, staff, and visitors. 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) and was issued at a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license. The facility was licensed for a capacity of fifteen and had a current census of fifteen residents. On January 2, 2024, at 10:00 a.m., during the entrance conference, the licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee had a staffing policy. On January 3, 2024, at 11:30 a.m., CNS-B stated she knew the staffing plan needed to be reviewed twice per year, the plan is reviewed depending on census and resident's needs, but did not think it was documented anywhere. On October 4, 2024, at 12:00 p.m., LALD-A stated he found no documentation of the staffing policy being reviewed twice a year as required. The licensee's Staffing policy dated February 2021, indicated staffing plans are documented and maintained in the file in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 3 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to	0 580		

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0 580	Continued From page 4 be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. 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) 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 2, 2024, at 10:00 a.m., during the entrance conference, the surveyor asked clinical nurse supervisor (CNS)-B for the documentation of the licensee's quality management activities. CNS-B stated the licensee recently completed an updated activity assessment and was hoping to increase activities as many of the residents like to sit in their rooms, however there was no formal meeting or documentation and was something the licensee was working on. On January 4, 2023, at 12:00 p.m., licensed	0 580		

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0 580	Continued From page 5 assisted living director (LALD)-A stated the licensee does not have any quality management documentation. The licensee's policy on quality management was requested and was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). 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	0 630		

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0 630	Continued From page 6 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension (high blood pressure), malignant neoplasm of the colon (colon cancer), and hypothyroidism (underactive thyroid). R1's service plan dated September 16, 2023, indicated the resident received services which included medication management, assistance with showers, housekeeping, and laundry. On January 2, 2024, at 12:10 p.m., surveyor observed unlicensed personnel (ULP)-D administer R1's scheduled noon medications. R1's Vulnerability Assessment/Abuse Prevention Plan (IAPP) dated September 17, 2023, identified one area of vulnerability with interventions and a review of the resident's susceptibility to abuse another individual. R1's IAPP did not include a review of the resident's susceptibility to be abused by other individuals, including other vulnerable adults, or self-abuse. R2 R2's diagnoses included hypertension, arthritis, and hypothyroidism. R2's service plan dated October 2, 2023, indicated the resident received services which included medication management, assistance with showers as needed, housekeeping, and	0 630		

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0 630	Continued From page 7 laundry. On January 3, 2024, at 6:45 a.m., surveyor observed ULP-D administer R2's scheduled morning medications. R2's undated IAPP, identified one area of vulnerability with interventions and a review of the resident's susceptibility to abuse another individual. R2's IAPP did not include a review of the resident's susceptibility to be abused by other individuals, including other vulnerable adults, or self-abuse. On January 3, 2024, at 11:03 a.m., clinical nurse supervisor (CNS)-B and surveyor reviewed R1 and R2's IAPP's. CNS-B stated R1 and R2's IAPP did not include a review of the resident's susceptibility to abused by another individual, including other vulnerable adults and self-abuse. Additionally, she stated the IAPP was currently used for all the residents and wasn't aware of the specific content required in the IAPP. The licensee's Abuse, Neglect, and Exploitation Reporting policy dated November 2019, indicated the community ensures that all reporting abuse and neglect is handled in accordance with the state rules and regulations and that proper reporting procedures are followed when a case of abuse, neglect, or exploitation is reported. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 8 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to properly install a portable fire extinguisher. This deficient condition had the potential to affect all residents, staff, and visitors. The findings include: On January 2, 2024, at 11:00 a.m., survey staff toured the facility with maintenance (M)-N. During the tour, survey staff observed the Class K fire extinguisher stored on the floor in the dining room adjacent to the kitchen. Fire extinguishers must be properly installed to prevent them from being moved or damaged. During an interview on January 2, 2024, at 1:00 p.m., M-N verified the Class K fire extinguisher was improperly stored on the floor. M-N explained the fire extinguisher had not been mounted on the wall because it was very heavy. M-N stated the facility would install this fire extinguisher on the wall in a readily accessible location.	0 790		

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0 790	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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) 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 2, 2024, at 11:00 a.m., survey staff toured the facility with maintenance (M)-N. During the facility tour, survey staff observed the following:	0 800		

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0 800	Continued From page 10 1. In resident rooms 9, 12, and 14, door closers were disconnected on the doors opening into the corridor. Self-closing doors are important for fire safety as they prevent the spread of fire and smoke. M-N verified the door closers had been disconnected during the facility tour. M-N stated during the tour interview door closers were only disconnected on resident room doors when requested by the resident. M-N explained some residents felt their doors were difficult to open when the door closers were connected. 2. In the bathroom of resident room 2, the bidet was plugged into an extension cord duct taped to the wall. Extension cords must not be used as a substitute for permanent wiring. M-N verified the bidet was plugged into an extension cord during the tour interview and stated they were not aware the bidet had been installed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
0 810	Continued From page 11 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 12 The findings include: On January 2, 2024, maintenance (M)-N provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On January 2, 2024, at 11:00 a.m., survey staff toured the facility with M-N. During the facility tour, survey staff observed resident rooms 1 through 8 were not identified on the evacuation plans posted in the facility. M-N verified the evacuation plans failed to identify the location and number of all resident rooms during the facility tour interview. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. One training record dated October 19, 2023, for an employee training session on the facility FSEP was provided. During an interview with survey staff on January 2, 2024, at 1:00 p.m., M-N verified additional employee training records were not available. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided for review. During an interview with survey staff on January 2, 2024, at 1:00 p.m., M-N verified resident training records were not available. M-N stated residents had been trained annually but the	0 810		

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0 810	Continued From page 13 training was not documented. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by the lack of evacuation drill records. During an interview with survey staff on January 2, 2024, at 1:00 p.m., M-N verified the licensee had not met the evacuation drill frequency requirements and confirmed records were not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290		

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01290	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance notice for two of two employees (maintenance (M)-C, unlicensed personnel (ULP)-F). In addition, the licensee failed to affiliate employee background studies with the correct assisted living license for 8 of 12 employees (ULP-D, ULP-E, ULP-G ULP-H, licensed practical nurse (LPN)-I, ULP-J, ULP-K, ULP-L). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on January 3, 2024, at approximately 3:00 p.m. BACKGROUND STUDY CLEARANCE M-C M-C was hired on August 18, 2005, and had begun working under the assisted living with effective August 1, 2021, to provide maintenance upkeep to the buildings. On January 2, 2024, at 11:00 a.m., surveyor observed M-C touring the building with Minnesota Department of Health (MDH) engineer for survey	01290		

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01290	Continued From page 15 inspection. After the tour, M-C was observed conversing with residents and provided maintenance. M-C was not observed to be under direct supervision. M-C's employee record contained a cleared background study dated September 16, 2005, however, did not have a current background study in NETStudy 2.0. ULP-F ULP-F was hired October 1, 2002, and had begun working under the assisted living license effective August 1, 2021, to provide direct care services. On the licensee's January 2024 work schedule, ULP-F is scheduled to work six 8 hour shifts. ULP-F's employee record contained a cleared background study dated November 6, 2002, however, did not have a current background study in NETStudy 2.0. BACKGROUND STUDY AFFILIATION ULP-D ULP-D was hired on November 24, 1999, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. On January 3, 2023, at 6:54 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R2. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license.	01290		

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01290	Continued From page 16 ULP-E ULP-E was hired on August 16, 2023, and had begun working under the assisted living license to provide direct care to residents. ULP-E's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-G ULP-G was hired December 10, 1978, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-G's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-H ULP-H was hired on December 11, 2002, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-H's record lacked documentation of a cleared background study affiliated with the facility's license. LPN-I LPN-I was hired on January 11, 2023, and had begun working under the assisted living license to provide direct care to residents. LPN-I's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-J ULP-J was hired on March 9, 2020, and had	01290		

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01290	Continued From page 17 begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-J's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-K ULP-K was hired May 2, 2023, and had begun working under the assisted living license to provide direct care to residents. ULP-K's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-L ULP-L was hired June 28, 2023, and had begun working under the assisted living license to provide direct care to residents. ULP-L's record lacked documentation of a cleared background study affiliated with the facility's license. On January 3, 2023, at 12:45 a.m., LALD-A stated the above employees were employed at the facility, a couple could not be affiliated due to needing a driver's license and others were affiliated today. Additionally, he stated all the employees were affiliated under the health facility identification (HFID) 730, [facility name], both entities share the same management company. The surveyor had requested the NETStudy 2.0 roster on January 2, 2024, at 2:45 p.m. and again on January 3, 2024, at 10:00 a.m., but never received.	01290		

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01290	Continued From page 18 The licensee's Staffing policy dated February 2021, indicated background checks (criminal history check), dependent adult abuse check and child abuse checks are completed prior to employment on all employees providing direct services to tenants/residents. If a prospective employee has a criminal history or an abuse history, the prospective employee will not be employed by the program unless the department or human services has performed an evaluation and determined that the record does not warrant employment prohibition. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by Department of Human Services (DHS) that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information.	01290		

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01290	Continued From page 19 No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluattion supervisor review of the licensee's plan of correction on January 3, 2024, however, noncompliance remains at a scope and level of level three, widespread (l).	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment using the uniform assessment tool for ongoing 90-day assessments that included all required content for two of two residents (R1, R2). 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) 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: R1 R1's diagnoses included hypertension (high blood pressure), malignant neoplasm of the colon (colon cancer), and hypothyroidism (under active thyroid). R1's service plan dated September 16, 2023, indicated the resident received services which included medication management, assistance with showers, housekeeping, and laundry. On January 2, 2024, at 12:10 p.m., surveyor observed unlicensed personnel (ULP)-D administer R1's scheduled noon medications. R1's record included a 90-day Monitoring and Reassessment dated December 23, 2023. This assessment indicated R1 required assistance with showering, medication administration,	01620		

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01620	Continued From page 21 laundry and housekeeping. This assessment did not include all the elements on the uniform assessment tool as required. R2 R2's diagnoses included hypertension, arthritis, and hypothyroidism. R2's service plan dated October 2, 2023, indicated the resident received services which included medication management, assistance with showers as needed, housekeeping, and laundry. On January 3, 2024, at 6:45 a.m., surveyor observed ULP-D administer R2's scheduled morning medications. R2's record included a 90-day Monitoring and Reassessment dated December 10, 2023. This assessment indicated R2 required assistance with showering, medication administration, laundry and housekeeping. This assessment did not include all the elements on the uniform assessment tool as required. On January 4, 2024, at 11:53 a.m., clinical nurse supervisor (CNS)-B stated the 90-day Monitoring and Reassessment was the assessment tool being used for all residents and was not a comprehensive assessment using the uniform assessment tool Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in	01620		

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01620	Continued From page 22 this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was updated for one of one resident (R1).	01640		

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01640	Continued From page 23 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: R1's diagnoses included hypertension (high blood pressure), malignant neoplasm of the colon (colon cancer) and hypothyroidism (under active thyroid). R1's service plan dated September 16, 2023, indicated the resident received services which included medication management, including set-up and medication reminders, assistance with showers, housekeeping, and laundry. R1's Medication Management Plan dated September 16, 2023, indicated medication set-up and medication reminders three times a day. On January 2, 2024, at 12:10 p.m., surveyor observed unlicensed personnel (ULP)-D administer R1's scheduled noon medications. R1's Assessment of Need for Medication Management Services dated October 20, 2023, completed by clinical nurse supervisor (CNS)-B indicated resident was "reassessed at this time and [the resident] does not appear sure of when to take medications, has moved medications around in med boxes and has odd pills lying about in bathroom. Family agreed, set-up and give medications and when supply low, use	01640		

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01640	Continued From page 24 [name] pharmacy for set-up, staff to pass medications from set up." R1's Medication Management Plan dated October 20, 2023, indicated medication administration documented home health aide (HHA/ULP)/nurse in medication administration record and registered nurse (RN) supervisory visits weekly, but lacked all other information. R1's Service Plan dated September 16, 2023, indicated R1 received medication management services, but not medication administration. On January 3, 2023, at 11:35 a.m., CNS-B stated R1's service plan had not been updated to reflect staff are administering medications, and she must have missed updating the service plan. The undated Resident Assessment Process in your Community policy indicated the service plan must be revised, if needed, based on client review or reassessment. The provider must provide information to the client about changes to the provider's fee for services and how to contact the relevant State offices. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

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VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

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01730	Continued From page 25 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
01730	Continued From page 26 review, the licensee failed to reassess the individualized medication management plan for one of one resident (R1) with a change of condition. 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: R1's diagnoses included hypertension (high blood pressure), malignant neoplasm of the colon (colon cancer), and hypothyroidism (under active thyroid). R1's service plan dated September 16, 2023, indicated the resident received services which included medication management, including set-up and medication reminders, assistance with showers, housekeeping, and laundry. R1's Medication Management Plan dated September 16, 2023, indicated medication set-up and medication reminders three times a day. On January 2, 2024, at 12:10 p.m., surveyor observed unlicensed personnel (ULP)-D administer R1's scheduled noon medications. R1's Assessment of Need for Medication Management Services dated October 20, 2023, completed by clinical nurse supervisor (CNS)-B indicated resident was "reassessed at this time	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
01730	Continued From page 27 and [the resident] does not appear sure of when to take medications, has moved medications around in med boxes and has odd pills laying about in bathroom. Family agreed, set-up and give medications and when supply low, use [name] pharmacy for set-up, staff to pass medications from set up." R1's Medication Management Plan dated October 20, 2023, indicated medication administration documented home health aide (HHA)/nurse in medication administration record and registered nurse (RN) supervisory visits weekly, but lacked all other information required: -a statement describing the medication management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. Additionally, documentation of medication reconciliation was not provided.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
01730	Continued From page 28 On January 3, 2023, at 11:04 a.m., CNS-B stated R1 was changed from medication reminders to staff administering the medications and didn't complete the new medication plan for the resident, and I [CNS-B] "didn't get it done I guess". A policy was requested; however, the licensee did not provide a policy to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R1) who received medication management services. 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	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
01820	Continued From page 29 situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), malignant neoplasm of the colon (colon cancer), and hypothyroidism (under active thyroid). R1's service plan dated September 16, 2023, indicated the resident received services which included medication management, assistance with showers, housekeeping, and laundry. R1's Assessment of Need for Medication Management Services dated October 20, 2023, indicated resident to receive medication management services, to include administration of medications, storing and securing medications, monitoring of medications, coordinating refills, handling and implementing changes to prescriptions and communicating with the prescriber and pharmacy. On January 2, 2024, at 12:10 p.m., surveyor observed unlicensed personnel (ULP)-D administer R1's scheduled noon medications. R1's Medication Administration record dated December 1, 2023, through December 31, 2023, indicated the following scheduled medications had been administered: -Preservision AREDS 2 (supplement) once daily; -iron (supplement) 325 milligrams (mg) twice daily; -magnesium (supplement) 210 mg daily; -lisinopril (for blood pressure) 15 mg daily; -cetirizine (allergies) 10 mg daily; -simvastatin (for high cholesterol) 20 mg daily; -melatonin (for sleep) 2 mg daily;	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20135	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERGAS ASSISTED LIVING	405 EAST FRAZEE AVENUE VERGAS, MN 56587

(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
01820	Continued From page 30 -levothyroxine (for thyroid) 75 micrograms (mcg) daily -vitamin B12 (supplement) daily; -calcium/vitamin D (supplement) daily; -vitamin D3 (supplement) 2000 international unit (IU) daily; -naproxen (for pain) 220 mg, 2 tablets twice daily; -donepezil (for memory loss) 10 mg daily; and -memantine (for memory loss) 21 mg daily. R1's record lacked provider orders for the above medications. On January 4, 2023, at 11:52 a.m., clinical nurse supervisor (CNS)-B stated she did not have provider orders for R1's medications, and obtaining the signed orders must have been missed on admission. The licensee's Medication Administration policy dated November 2019, indicated the community supervises or administers all medications a resident receives as ordered by their physician. The community provides appropriate methods and procedures for obtaining, dispensing, and administering drugs approved by the resident's physician and consulting pharmacist. When a resident moves in, the community requires a doctor's order in writing. To meet policy and state regulations, all medications (including over-the-counter drugs) must have a doctors' order and a proper label on them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul MN, 55164
218-332-5150

Type: Full
Date: *01/03/24*
Time: 10:30:00
Report: 1048241001

Food and Beverage Establishment Inspection Report

Location:
Vergas Assisted Living
405 East Frazee Avenue
Vergas, MN56587
Otter Tail County, 56

Establishment Info:
ID #: 0039268
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183344501
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT LACKS MN STATE CFPM CERTIFICATE. ALEAH LEPISTO HAS A SERVSAFE CERTIFICATE AND NEEDS TO APPLY FOR CFPM CERTIFICATE WITH MDH. APPLICATION INFORMATION SENT VIA EMAIL.

Comply By: 01/03/24

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

THERE IS AN ACCUMULATION OF DUST AND GREASE ON THE VENT HOOD OVER THE STOVE. ENSURE HOOD IS CLEANED REGULARLY TO ELIMINATE THE BUILD UP OF GREASE AND DUST.

Comply By: 01/03/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

THE WALL ADJACENT TO THE STOVE IS UNCLEAN AND HAS A BUILD UP OF FOOD SPLASH. ENSURE FLOORS, WALLS, AND CEILINGS ARE CLEANED REGULARLY TO ELIMINATE FOOD DEBRIS BUILDUP.

Comply By: 01/03/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

THE AIR VENT IN THE KITCHEN IS UNCLEAN AND HAS AN ACCUMULATION OF DUST. ENSURE VENTILATION SYSTEMS ARE CLEANED REGULARLY TO AVOID DUST BUILDUP AND POTENTIAL KITCHEN CONTAMINANTS.

Comply By: 01/03/24

Surface and Equipment Sanitizers

Hot Water: = at 164 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 300ppm at Degrees Fahrenheit
Location: Sanitizer spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Milk- reach in cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Sliced deli ham- reach in cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Potato salad- reach in cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: *01/03/24*
Time: 10:30:00
Report: 1048241001
Vergas Assisted Living

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1048241001 of 01/03/24.

Certified Food Protection Manager: NEEDED

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: _____
Bailey Bannon
Environmental Health Specialist
Fergus Falls District Office
bailey.bannon@state.mn.us

Report #: 1048241001

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul MN, 55164

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/03/24
Time In 10:30:00
Time Out

Vergas Assisted Living	Address: 405 East Frazee Avenue	City/State: Vergas, MN	Zip Code: 56587	Telephone: 2183344501
License/Permit #: 0039268	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/03/24

Inspector (Signature)