Electronically Delivered

February 6, 2025

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

RE: Project Number(s) SL20135016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

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

JMD

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 _____	12/18/2024

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 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: SL20135016-0 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 13 residents; 13 receiving services under the Assisted Living Facility license.	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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 16, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-D, licensed practical nurse (LPN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 4 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 16, 2024, at 9:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record. ULP-D ULP-D was hired on November 24, 1999, and had begun to provide direct assisted living services to residents at the facility on August 1, 2021. On December 16, 2024, at 12:47 p.m., the surveyor observed unlicensed personnel (ULP)-D complete scheduled medication administration to R3. ULP-D's employee record lacked documentation of training and a competency evaluation for resident's unplanned time away. On December 17, 2024, at 8:01 p.m., ULP-D stated ULP-D was trained, and competency tested for resident's unplanned time away by CNS-B on June 7, 2024, during a staff meeting. On December 18, 2024, at 2:05 p.m., CNS-B stated CNS-B completed unplanned time away training and competency evaluations for all ULPs employed at the facility during a staff meeting on June 7, 2024, however, CNS-B stated CNS-B	0 650		

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0 650	Continued From page 5 only documented the unplanned training and competency evaluations in the staff meeting minutes, and did not document the unplanned time away training and competency evaluations in any of the ULP's employee records LPN-C LPN-C was hired on January 11, 2023, to provide supervision of staff and residents at the facility. LPN-C's employee record lacked topics of orientation to assisted living training regarding the following: -overview of assisted living; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and service delivery and how they apply to director support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 17, 2024, at 12:51 p.m., CNS-B stated CNS-B trained staff at the facility to all topics on orientation to assisted living on June 7, 2024, during a staff meeting, however, CNS-B	0 650		

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0 650	Continued From page 6 documented the training on the staff meeting minutes, and CNS-B did not document the orientation to assisted living topics in LPN-C's employee record. The licensee's Training Documentation policy dated June 19, 2023, indicated a record of staff training and competency will be maintained. Each competency evaluation, training, retraining, and orientation topic will have the following documentation: -facility name and location; -facility license number; -training topic or training program; -training methodology (classroom, web-based training, video, one-to-one); -date of the training and/or competency evaluation; -total amount of time for the training and competency evaluation; -name and title of the instructor; -instructor's signature; -name and title of the competency evaluator if different from the instructor; -competency evaluator's signature if different from the instructor; -evaluator statement attesting the employee successfully completed the training and competency evaluation; -name and title of staff person completing the training; -staff person's signature; and -staff person statement attesting the staff person successfully completed the training as described. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that	0 650		

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0 650	Continued From page 7 documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

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01530	Continued From page 8 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (licensed practical nurse (LPN)-C) received the required amount of dementia care training in the required time frame. 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:	01530		

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01530	Continued From page 9 During the entrance conference on December 16, 2024, at 9:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record. LPN-C was hired on January 11, 2023, to provide supervision of staff and residents at the facility. LPN-C's Relias (online training platform) Transcript dated December 16, 2024, indicated LPN-C had completed six and a half hours of dementia training from January 14, 2023, through December 16, 2024. LPN-C's employee record lacked eight hours of dementia training within 120 hours of the employee start date for supervision of direct-care staff. On December 18, 2024, at 2:06 p.m., licensed assisted living director (LALD)-A stated LPN-C was short an hour and a half of initial dementia training and LPN-C had worked more than 120 hours since the start of employment. LPN-C further stated LPN-C provided direct supervision to staff at the facility and LPN-C had misunderstood the initial amount of required dementia training for employees who supervised direct-care staff. The licensee's Dementia-specific [sic] Education policy dated February 2021, indicated all employees receive eight hours of training within 30 days of employment that includes: -an explanation of Alzheimer's disease and related disorders; -the program's specialized dementia care philosophy and program; -skills for communicating with persons with dementia;	01530		

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01530	Continued From page 10 -an explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the caregiving role, and family dynamics; -the importance of planned and spontaneous activities; -skills in providing assistance with instrumental activities of daily living; -the importance of the service plan and social history information; -skills in working with challenging tenants/residents; -techniques for simplifying, cueing, and redirecting; -staff support and stress reduction; and -medication management and non-pharmacological interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=C	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	01620		

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01620	Continued From page 11 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. 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) conducted assessments with the uniform assessment tool that included all required content for two of two residents (R3, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: During the entrance conference on December 16, 2024, at 9:13 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R3 R3's diagnoses included hypertension (HTN-high blood pressure) and chronic kidney disease,	01620		

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01620	Continued From page 12 R3's MN (Minnesota)- Senior Living- Level of Care and Service Plan (assessments) were completed September 6, 2024, and November 25, 2024, respectively. On December 16, 2024, at 12:47 p.m., the surveyor observed unlicensed personnel (ULP)-D complete scheduled medication administration to R3. R5 R5's diagnoses included HTN and diabetes. R5's MN (Minnesota)- Senior Living- Level of Care and Service Plan (assessments) were completed September 6, 2024, and November 17, 2024, respectively. On December 17, 2024, at 7:55 a.m., the surveyor observed ULP-D complete scheduled morning medication administration to R5. R3 and R5's MN (Minnesota)- Senior Living- Level of Care and Service Plans lacked the resident's personal lifestyle preferences including spiritual and cultural preferences required from the uniform assessment tool as identified in Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subp. 2. On December 17, 2024, at 12:57 p.m., CNS-B stated the same assessments were used for all residents and a resident's spiritual and cultural preferences were assessed one time per year on the resident's activity evaluation. The licensee's Resident Initial and On-going [sic] Assessments policy dated June 19, 2023, indicated an RN would complete comprehensive assessments at least every 90 days as outlined	01620		

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 _____	12/18/2024

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
01620	Continued From page 13 by Minnesota rules (Minnesota Assisted Living Rules), which included the resident's spiritual and cultural preferences. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.	01710		

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 _____	12/18/2024

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
01710	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of two residents (R5). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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: During the entrance conference on December 16, 2024, at 9:18 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R5's diagnoses included hypertension (HTN-high blood pressure), diabetes, and breast cancer. R5's service plan dated January 4, 2024, indicated R5's services included medication administration one to two times daily. R5's prescriber orders dated February 15, 2024, included an order for acetaminophen 500 milligrams (mg) tablets give two tablets by mouth every 4 hours as needed for pain or fever. R5's record lacked a prescriber order for melatonin to use as needed at night to assist in falling asleep. On December 17, 2024, at 7:55 a.m., the	01710		

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 _____	12/18/2024

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
01710	Continued From page 15 surveyor observed unlicensed personnel (ULP)-D complete scheduled morning medication administration to R5. R5's Individualized Medication Management Plan dated November 17, 2024, indicated R5 was able to manage use of R5's acetaminophen and melatonin PRN (as needed). R5's Self-Administration of Medications Review Tool dated November 27, 2024, indicated it was not applicable for R5 to demonstrate secure storage for non-controlled medication by locking R5's door upon departure, no physician order to self-administer medications, R5 was not granted approval for self-administration of medications due to cognition issues, and staff administered all medications. R5's record lacked an updated Individualized Medication Management Plan for medication administration and medication storage of PRN medications after R5 was no longer self-managing PRN medications. On December 17, 2024, at 1:03 p.m., CNS-B stated it must have been an oversight not to update R5's Individual Medication Management Plan since R5 was no longer self-administering PRN medications. The licensee's Medication Administration-Unlicensed Staff policy dated November 2019, indicated licensed nurse conducts face-to-face assessment to determine what medication management services will be provided and how those services will be provided. In addition, the licensed nurse specifies, in writing, instructions for each resident and documents those instructions in the resident's record.	01710		

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 _____	12/18/2024

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

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01710	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *12/16/24*
Time: 11:30:00
Report: 1049241272

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

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
PIC INSTRUCTED TO POST THE CFPM CERTIFICATE AT THE ESTABLISHMENT.
Comply By: 12/16/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
ESTABLISHMENT HAS A PART ON ORDER TO FIX THE DISH MACHINE. THE ESTABLISHMENT IS USING THE 2-COMPARTMENT SINK AND ANOTHER CONTAINER TO WASH, RINSE AND SANITIZE DISHES AND UTENSILS IN THE MEANTIME.
Comply By: 12/16/24

Food and Equipment Temperatures

Process/Item: Upright Cooler-Kitchen
Temperature: 34 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler-Kitchen
Temperature: 36.5 Degrees Fahrenheit - Location: Lettuce
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler-Kitchen
Temperature: 37 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Upright Cooler-Office
Temperature: 35.5 Degrees Fahrenheit - Location: Peaches
Violation Issued: No

Process/Item: Upright Cooler-Office
Temperature: 32.5 Degrees Fahrenheit - Location: Lettuce
Violation Issued: No

Process/Item: Cooking
Temperature: 193.5 Degrees Fahrenheit - Location: Noodles with Broccoli
Violation Issued: No

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

INSPECTOR MET WITH THE NURSE EVALUATOR AND THE ESTABLISHMENT REPRESENTATIVE.

THE ESTABLISHMENT IS USING QUATERNARY AMMONIA TO SANITIZE DISHES AND UTENSILS, AS WELL AS TO SANITIZE OTHER FOOD CONTACT SURFACES.

KITCHEN AND DISH ROOM WALLS WERE FRP, FLOORS WERE TILE, AND THE CEILINGS WERE ACOUSTIC DROP CEILING TILES.

FOOD PREP SURFACES WERE STAINLESS STEEL PREP TABLES.

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: *12/16/24*
Time: 11:30:00
Report: 1049241272
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 1049241272 of 12/16/24.

Certified Food Protection Manager: Melissa Lynn Moe

Certification Number: 53282 Expires: 09/23/27

Signed: _____
Establishment Representative

Signed: *Stephanie Reynolds*
Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049241272

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls

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

Date 12/16/24
Time In 11:30:00
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	X	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		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/16/24

Inspector (Signature) Stephanie Reynolds