Electronically Delivered

December 5, 2024

Licensee
Remmy's Tender Care LLC Limited Liability Company
1439 Sherburne Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL39996015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 24, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 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 Department of Health 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39996	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMMYS TENDER CARE LLC LIMITED LIABIL	1439 SHERBURNE AVENUE SAINT PAUL, MN 55104

(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: SL# 39996015 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 2 resident(s); 2 receiving services under the Provisional 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the 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 October 21, 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		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of one employee, unlicensed personnel (ULP)-C. 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:	0 660		

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0 660	Continued From page 3 ULP-C began employment on June 19, 2024, to perform direct care services to the licensee's residents. On October 21, 2024, at 12:36 p.m., the surveyor observed ULP-C provide scheduled medication administration to R1. ULP-C's employee record contained a consent and release for TB screening dated June 19, 2024, and a negative QuantiFERON TB Gold blood test dated December 23, 2023. The blood test result was greater than 90 days prior to the June 19, 2024, hire date. On October 22, 2024, at 9:35 a.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated they believed the results on file met the TB test requirements. The licensee's Tuberculosis Screening/Prevention policy dated March 22, 2023, indicated [the facility] will observe the recommended precautions related to TB prevention as identified by the CDC and Minnesota Department of Health (MDH). The precautions include risk assessment, TB screening and staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 4 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. 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	0 680		

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0 680	Continued From page 5 portion or all the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: - missing resident quarterly review -subsistence needs for staff and patients -procedures for tracking of staff and patients -policies and procedures for medical documents - policies and procedures for volunteers On October 22, 2024, at 11:45 a.m., clinical nurse supervisor/assisted living director in residence (CNS/ALDIR)-A stated they are aware that updates are needed in the emergency plan. CNS/ALDIR-A and administrator (A)-B are working on completing it. The licensee's Emergency Preparedness policy dated March 22, 2023, indicated [the Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=D	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	0 800		

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0 800	Continued From page 6 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 a limited number of 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 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: On October 22, 2024, at 11:45 a.m., the surveyor toured the facility with clinical nurse supervisor / assisted living director in residence (CNS/ALDIR)-A and administrator (A)-B. During the tour, the surveyor observed the following: 1. An extension cord was plugged into a wall outlet in the hallway outside the sleeping rooms on the upper floor level. This extension cord ran under the door and into occupied resident sleeping room 3 where it was used to provide power to a lamp. 2. The exterior light fixture for the front door was missing. There was an empty light fixture baseplate above the front door.	0 800		

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0 800	Continued From page 7 During the facility tour interview on October 22, 2024, PCNS/ALDIR-A and A-B verified the above listed observations. 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 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	0 810		

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0 810	Continued From page 8 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 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). The findings include: On October 22, 2024, CNS/ALDIR-A and A-B 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 October 22, 2024, at 11:45 a.m., the surveyor toured the facility with clinical nurse supervisor / assisted living director in residence (CNS/ALDIR)-A and administrator (A)-B. During the tour, the surveyor observed room numbers were posted on the door for each resident	0 810		

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0 810	Continued From page 9 sleeping room. The surveyor observed the posted FSEP floor plan dated 2023-01-08 did not include sleeping room number labels. Resident sleeping rooms are required to be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, CNS/ALDIR-A and A-B verified the resident sleeping rooms were not accurately identified on the floor plan. Record review of the available documentation indicated the licensee had not developed a FSEP relative to the facility's building layout and environmental risks. The FSEP included a Fire Safety Policy dated March 22, 2023, that was a template from a third party provider and had not been developed for use at this facility. The FSEP inaccurately referenced pull fire alarms, which were not installed at this facility. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency. The plan indicated to use the RACE acronym (Remove, Alarm, Confine, Evacuate/Extinguish) and included vague instructions for employees. The plan did not provide complete actions for employees to take in the event of a fire or similar emergency. The FSEP failed to identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The FSEP directed employees to evacuate residents but failed to provide specific procedures	0 810		

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0 810	Continued From page 10 for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview on October 22, 2024, at 1:00 p.m., CNS/ALDIR-A and A-B verified the FSEP required revision. 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 evident by fire drill reports lacking the required frequency. Fire drill reports were dated June 17, 2024, and September 16, 2024. CNS/ALDIR-A and A-B verified the evacuation drill frequency was not met and stated no additional fire drills had been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	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	01290		

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01290	Continued From page 11 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: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for three of five employees (unlicensed personnel/ULP-C, ULP-D, ULP-E) on the facility provided employee roster. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On October 21, 2024, at 2:47 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered three of the facility's five employees were not affiliated with the licensee's HFID 39996. ULP-C was hired on June 19, 2024, to provide direct care and services to the licensee's residents. A background study was submitted on October 14, 2024, and was in process for HFID 39996. ULP-D was hired on June 12, 2024, to provide direct care and services to the licensee's	01290		

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01290	Continued From page 12 residents. A background study had not been completed. ULP-E was hired on July 10, 2024, to provide direct care and services to the licensee's residents. A background study was submitted on October 14, 2024, and was in process for HFID 39996. On October 22, 2024, at 10:43 a.m., administrator (A)-B stated she reviewed the NETSudy 2.0 roster two weeks prior and noted that three employees were not affiliated with HFID: 39996. A-B submitted background studies for ULP-C and ULP-E on October 14, 2024 and stated they are unsure why they are still listed as in process. A-B called the NETStudy 2.0 help desk and is awaiting a response. A-B stated that ULP-D's background study was processed today. They are aware of the background study requirements. The licensee's Personnel Records policy dated March 22, 2023, indicated results of a background study will be kept in the personnel record for each staff member. No further information was provided. TIME PERIOD FOR CORRECTION: 2 days	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39996	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMMYS TENDER CARE LLC LIMITED LIABIL	1439 SHERBURNE AVENUE SAINT PAUL, MN 55104

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01620	Continued From page 13 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor clinical nurse supervisor/ assisted living director in residence (CNS/ALDIR)-A completed a comprehensive nursing reassessment to include all required content identified per Minnesota (MN) Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39996	A. BUILDING: _____ B. WING _____	10/24/2024

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01620	Continued From page 14 a large portion or all of the residents). The findings include: R1 was admitted on July 17, 2024. R1's Nurse Reassessment Visit dated October 17, 2024, was a two (2) page document identified by CNS/ALDIR-A as R1's 90-day reassessment. The document was signed as completed by CNS/ALDIR-A R1's 90-day assessment did not include the following required elements on the uniform assessment tool: -the resident's personal lifestyle preferences, including sleep schedule and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences and advance health care directives and end-of-life preferences - activities of daily living, including grooming, dental status, oral care, and dentures. - physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life threatening, infectious conditions, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months - emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39996	A. BUILDING: _____ B. WING _____	10/24/2024

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01620	Continued From page 15 bipolar disorder, and thought or behavioral disorders, effective medication treatment and non medication interventions - cognition, including a review of any neurocognitive evaluations and diagnoses - communication and sensory capabilities, including speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood -nutritional and hydration status and preferences - list of treatments, including type, frequency, and level of assistance needed - nursing needs, including potential to receive nursing-delegated services - risk indicators including risk for falls including history of falls, emergency evaluation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician - who has decision making authority for the resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker under subitem (1) - the need for follow-up referrals for additional medical or cognitive care by health professionals On October 22, 2024, at 10:07 a.m., CNS/ALDIR-A stated the two page assessment tool was used for all reassessments. She did not	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 16 realize the form did not contain the required content. The licensee's Comprehensive Nursing Assessment policy dated March 22, 2023, stated the registered nurse will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *10/21/24*
Time: 10:56:24
Report: 8058241268

Food and Beverage Establishment Inspection Report

Location:
REMMYS TENDER CARE LLC LIMITED
1439 SHERBURNE AVENUE
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0043728
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

ITEMS SUCH AS OPENED DELI MEAT NOT DATE MARKED - COS

Comply By: 10/21/24

Surface and Equipment Sanitizers

Hot Water: = --- at 160 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR: LISA SCHWINTEK

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *10/21/24*
Time: 10:56:24
Report: 8058241268
REMMYS TENDER CARE LLC LIMITED

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 8058241268 of 10/21/24.

Certified Food Protection Manager: CHIATUOGO UKAGA

Certification Number: 116623 Expires: 04/17/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHIATUOGO UKAGA
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us