Electronically Delivered

September 26, 2024

Licensee
SMC ASHTON INC
9300 Northwood Parkway
New Hope, MN 55427

RE: Project Number(s) SL34331015

Dear Licensee:

On August 27, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 6, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Electronically Delivered

July 12, 2024

Licensee
Smc Ashton Inc.
9300 Northwood Parkway
New Hope, MN 55427

RE: Project Number(s) SL34331015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 6, 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	34331	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	9300 NORTHWOOD PARKWAY NEW HOPE, MN 55427

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34331015-0 On June 4, 2024, through June 6, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the provider's Assisted Living 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 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 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 June 4, 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		
0 800 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,	0 800		

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0 800	Continued From page 2 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 maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the 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, 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). Findings include: On June 4, 2024, survey staff toured the facility with licensed assisted living director (LALD)-A, and observed the following maintenance issues: 1. Concrete doorsteps, in the front entrance outside, are cracked and coming apart from the concrete pad in front of them. 2. Resident bedroom #5 vent and light cover is coming off the ceiling. 3. Basement bathroom is missing a floor tile and has heavily dust buildup in the ventilation fan on the ceiling.	0 800		

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0 800	Continued From page 3 4. Laundry room ceiling tiles have yellow stains on some of them from past water leak. 5. Storage room in the basement has black marks on the wall that looks like mold. Carpet is heavily ripped and stained. Storage items in this room including a bed are heavily soiled. 6. Rain gutter by the porch is falling off the building. 7. All the walls throughout this facility are stained and soiled and could use a good cleaning and fresh paint. 8. Cigarette butts and ashes were present on the sun porch window ledge and porch floor with no proper cigarette butt receptacle to put them in. 9. Main floor bathroom vanity was missing door knobs and paint. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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0 820	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a properly sized egress window for a resident room that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. 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 June 05, 2024, at 8:40 a.m., survey staff conducted a facility tour with licensed assisted living director (LALD)-A. During facility tour, survey staff observed and verified egress window measurement of the openable area to be 20.75" high x 30.5" wide for a total of 632 square inches in unoccupied resident room #3. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". TIME PERIOD FOR CORRECTION: Immediate	0 820		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 5 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 6 Based on interview and record review, the licensee failed to ensure training and competency was completed with all required content for one of one employee (unlicensed personnel (ULP)-D). 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: ULP-D was hired April 5, 2023, and provided care and services to licensee's assisted living residents. ULP-D's employee record lacked documentation of competency evaluations for ULP providing assisted living services including: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On June 6, 2024, at 7:44 a.m., clinical nurse supervisor (CNS)-H, via email, stated "It was brought to my attention at a survey earlier this year that I needed to specifically list out key competencies on our training form. I have been updating these forms for all staff and retraining where necessary. Unfortunately, I am not 100% complete with this process and still have a handfull of staff to visit, [ULP-D] being one of them. I do believe [ULP-D] was trained by the	01370		

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01370	Continued From page 7 previous RN on all competencies prior to [licensee] acquiring [the facility]; however, I cannot locate evidence of this." The licensee's Assisted Living Orientation-ULP Staff policy dated January 1, 2024, indicated newly hired unlicensed personnel would receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. Furthermore, unlicensed personnel who are not a registered nursing assistant would receive additional training with a written or oral competency test, and a skills demonstration on the following topics: -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and -standby assistance techniques and how to perform them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 8 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed with all required content for one of one employee (unlicensed personnel (ULP)-D). 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: ULP-D was hired April 5, 2023, and provided direct care and services to licensee's assisted living residents. ULP-D's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: - range of motion and positioning. On June 6, 2024, at 7:44 a.m., clinical nurse supervisor (CNS)-H, via email, stated "It was	01380		

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01380	Continued From page 9 brought to my attention at a survey earlier this year that I needed to specifically list out key competencies on our training form. I have been updating these forms for all staff and retraining where necessary. Unfortunately, I am not 100% complete with this process and still have a handful of staff to visit, [ULP-D] being one of them. I do believe [ULP-D] was trained by the previous RN on all competencies prior to [licensee] acquiring [the facility]; however, I cannot locate evidence of this". The licensee's Staff Competency policy dated August 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks, prior to working for the licensee. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP providing assisted living services must include: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - administration of medication and treatments, as required; and - range of motion and positioning. No further information was provided.	01380		

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01380	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders 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 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).	01760		

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01760	Continued From page 11 The findings include: R1 admitted and began receiving assisted living services on March 27, 2024. R1's diagnoses included adjustment disorder with depressed mood, post-traumatic stress disorder, alcohol dependency, anxiety, stimulant abuse, and type 2 diabetes mellitus without complications. R1's assisted living service plan dated March 27, 2024, indicated R1 received services including assistance with homemaking, shopping, meal preparation, medication management, medication reminders, and medication administration. R1's electronic medication administration record (EMAR) dated June 2024, indicated the following medications were to be administered daily at 12:00 p.m.: -Acampro Cal 333 milligram (mg) tablet, administer two tablets by mouth three times daily; -Bupren/Nalox Sub 8-2 mg, administer one tablet under the tongue twice daily for 28 days; -Gabapentin 300 mg tablet, administer one tablet by mouth three times daily; and -lactulose solution 10 grams (G)/15 milliliter (ml), administer 45 ml by mouth four times daily. R1's Physician Order Sheet, signed April 18, 2024, included lactulose solution 10 G/15 ml, administer 45 ml by mouth four times daily. On June 4, 2024, at 11:07 a.m., surveyor observed unlicensed personnel (ULP)-D remove R1's lactulose solution from the medication cart, pour 35ml of lactulose solution into a plastic medication cup, and hand the plastic cup to R1 for oral administration.	01760		

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	34331	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	9300 NORTHWOOD PARKWAY NEW HOPE, MN 55427

(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
01760	Continued From page 12 -ULP-D stated, "I only administered 35 ml because that was all that was left in the bottle." ULP-D further stated the registered nurse was aware that a refill was needed, and that the medication refill would be delivered this week. On June 4, 2024, at 2:41 p.m., registered nurse (RN)-C stated they would typically contact R1's pharmacy when a refill was needed, and the pharmacist would reach out to the physician to authorize refills. RN-C further stated she would review R1's medical record for any notes pertaining to medication refills. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated January 1, 2024, indicated medications would be administered according to the "6 Rights" which included right dose. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to store all prescription medications according to the manufacturer's directions for one of one resident (R2), with	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34331	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	9300 NORTHWOOD PARKWAY NEW HOPE, MN 55427

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01880	Continued From page 13 refrigerated medications. 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: R2 had diagnoses to include type 2 diabetes mellitus with underlying conditions. R2's service plan, dated February 20, 2024, indicated R2 received services including assistance with medication set-up and medication administration. R2's medication and treatment administration record dated June 2024, indicated unlicensed personnel (ULP) or registered nurse (RN) would administer 40 units of insulin via Humalog Mix 75/25 KwikPen U-100 (used to assist in controlling blood sugar levels), subcutaneous (under the skin), twice daily, before meals, at 8:00 a.m., and 8:00 p.m. On June 5, 2024, at 8:02 a.m., surveyor observed ULP-D remove Humalog Mix 75/25 KwikPen U-100 from the medication cart, obtain an alcohol prep pad, and dialed the pen to administer 40 units of insulin. ULP-D handed the alcohol prep pad to R2, R2 wiped the injection site, and ULP-D handed the insulin pen to R2 for self-injection of insulin. On June 5, 2024, at 8:45 a.m., the medication	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34331	A. BUILDING: _____ B. WING _____	06/06/2024

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01880	Continued From page 14 refrigerator was observed. The temperature reading of the thermometer in the refrigerator was 30 degrees Fahrenheit (°F). Inside the refrigerator were five, unopened Humalog Mix 75/25 KwikPens which belonged to R2. The licensee's "Daily Medication Refrigerator Temperature Log" dated June 2024, indicated, refrigerator temperature readings from June 1, 2024, through June 5, 2025, ranged from 30°F to 36°F (1.1 degrees Celsius (°C) to 2.2°C). On June 5, 2024, at 8:45 a.m., RN-C stated the licensee lacked manufacturer's instructions for insulin storage. On June 5, 2024, at 8:50 a.m., ULP-D and RN-B stated refrigerator temperatures were taken and recorded daily. RN-B further stated the licensee's temperature parameters were between 33°F to 41°F (0.6°C to 5°C), as licensee would not want insulin to freeze. The HUMALOG® Mix 75/25 KwikPen manufacture prescribing information dated July 2023, indicated, "Unused HUMALOG® Mix 75/25 KwikPens should be stored in a refrigerator between 36°F to 46°F (2°C to 8°C). Do not freeze HUMALOG® Mix 75/25 KwikPen and do not use HUMALOG® Mix 75/25 KwikPen if it has been frozen." The licensee's "Storage of Medications" policy dated January 1, 2024, indicated licensee would conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications. Furthermore, the RN would provide education to the resident/resident's representative on proper	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 15 storage of medications in the home, including the need to be refrigerated, or stored in a cool, dry area, according to manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *06/04/24*
Time: 11:30:00
Report: 1043241137

Food and Beverage Establishment Inspection Report

Location:
Ashton Homes Llc
9300 Northwood Parkway
New Hope, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0038886
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633540850
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SAUSAGE STORED OVER READY-TO-EAT FOODS (BLUEBERRIES, VEGETABLES) IN KITCHEN COOLER. ADVISED STAFF TO RELOCATE RAW MEAT BELOW READY-TO-EAT FOODS. STAFF CORRECTED ON SITE.

Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.19

MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.

RESTROOM DOOR UPSTAIRS AND DOWNSTAIRS OBSERVED OPENED. ADVISED STAFF TO CLOSE DOORS IN BETWEEN USAGE TO HELP PREVENT PEST CONTAMINATION. COMPLY WITH ABOVE RULE.

Comply By: 06/04/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

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

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

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

Process/Item: SAUSAGE
Temperature: 53 Degrees Fahrenheit - Location: COOLING FROM AMBIENT
Violation Issued: No

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

Inspection was completed with Anna Rollag among others. Rhonda Makela was the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

**Foods cooked by the facility staff should be fully cooked and prepared for same day service only with leftovers discarded.

**This facility has a residential kitchen with residential equipment. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241137 of 06/04/24.

Certified Food Protection Manager: Anna Patricia Rollag

Certification Number: FM122088 Expires: 03/19/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Anna Patricia Rollag
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us