



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 15, 2024

Licensee

Ashton Homes LLC

7523 Humboldt Circle North

Brooklyn Park, MN 55444

RE: Project Number(s) SL35078016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no 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.

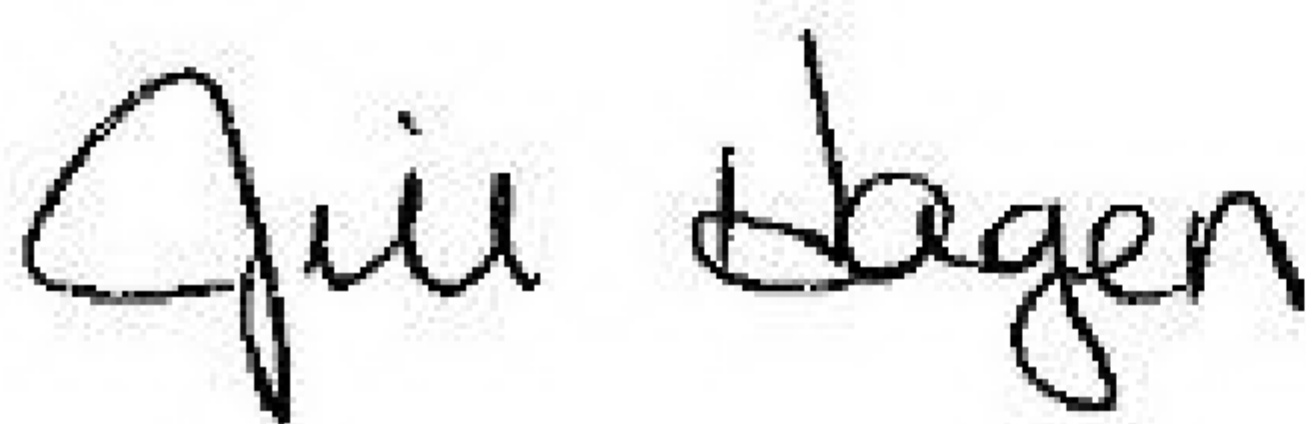
To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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,

A handwritten signature in black ink that reads "Jill Hagen". The signature is written in a cursive, flowing style.

Jill Hagen, Supervisor

State Rapid Response Team

Email: [jill.hagen@state.mn.us](mailto:jill.hagen@state.mn.us)

Telephone: 218-770-8646 Fax: 1-800-337-9238

HHH

Minnesota Department of Health

|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>35078</b>                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SMC ASHTON INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7523 HUMBOLDT CIRCLE NORTH<br/>BROOKLYN PARK, MN 55444</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                     | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING<br><br>INITIAL COMMENTS:<br>#SL35078016<br><br>On January 29, 2024, the Minnesota Department<br>of Health conducted a CHOW (change of<br>ownership) survey at the above provider, and no<br>correction orders are issued. At the time of the<br>survey and investigation, there were 4 residents<br>receiving services under the provider's Assisted<br>Living Facility license.                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 000                                                                                                  |                                                                                                                          |  |                                                        |
| 0 480<br>SS=F                                             | 144G.41 Subd 1 (13) (i) (B) Minimum<br>requirements<br><br>(13) offer to provide or make available at least the<br>following services to residents:<br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the licensee failed to ensure food was<br>prepared and served according to the Minnesota<br>Food Code.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>the residents). | 0 480                                                                                                  |                                                                                                                          |  |                                                        |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>35078</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SMC ASHTON INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7523 HUMBOLDT CIRCLE NORTH<br/>BROOKLYN PARK, MN 55444</b>                   |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                     | <p>Continued From page 1</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 29,2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Corrected during the on-site inspection.</p> | 0 480                                                                     |                                                                                                                          |  |                                                        |

Type: Full  
Date: 01/29/24  
Time: 12:31:29  
Report: 1004241014

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Ashton Homes Llc  
7523 Humboldt Circle North  
Brooklyn Park, MN55444  
Hennepin County, 27

**Establishment Info:**

ID #: 0038325  
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 SHELL EGGS FOUND STORED OVER PRODUCE IN KITCHEN REFRIGERATOR. DISCUSSED STORAGE ORDER REQUIREMENTS WITH STAFF ON SITE. EGGS WERE MOVED TO BOTTOM DRAWER DURING INSPECTION \*CORRECTED ON SITE.

Comply By: 01/29/24

### Food and Equipment Temperatures

Process/Item: MILK

Temperature: 37 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: CHEESE

Temperature: 38 Degrees Fahrenheit - Location: KITHCEN REFRIGERATOR

Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY YOLANDA DAWSON.

\*ESTABLISHMENT HAS UNDERGONE A CHANGE OF OWNERSHIP. NEW NAME ON LICENSE IS "SMC ASHTON INC"

Type: Full  
Date: 01/29/24  
Time: 12:31:29  
Report: 1004241014  
Ashton Homes Llc

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# Food and Beverage Establishment Inspection Report

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## DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- SANITIZER USE
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES
- PEST CONTROL
- PHYSICAL FACILITIES AND MAINTENANCE

\*REPORT WAS DISCUSSED WITH THE OPERATOR, DUKE, AND WITH THE NURSE EVALUATOR, YOLANDA.

\*FLOORS ARE LAMINATE, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE PAINTED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

\*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

\*ESTABLISHMENT HAS A HIGH TEMPERATURE SANITIZING DISH MACHINE THAT IS TESTED BY STAFF ROUTINELY.

\*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full  
Date: 01/29/24  
Time: 12:31:29  
Report: 1004241014  
Ashton Homes Llc

# Food and Beverage Establishment Inspection Report

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**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 1004241014 of 01/29/24.

Certified Food Protection Manager SHEIKH K. DUKULY II

Certification Number: FM109724 Expires: 02/10/25

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

SHEIKH K. DUKULY II  
OPERATOR

Signed: Molly Dougherty

Molly Dougherty  
Public Health Sanitarian  
Metro District Office  
651-201-3978  
molly.dougherty@state.mn.us