



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 11, 2026

Licensee

Smc Ashton Inc.

7435 78th Court North

Brooklyn Park, MN 55445

RE: Project Number(s) SL34562016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 15, 2026, 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 . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

- Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

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

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

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.

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,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER SMC ASHTON INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 78TH COURT NORTH BROOKLYN PARK, MN 55445			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34562016-0 On July 13, 2026 through July 15, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four 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			

Minnesota Department of Health

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

TITLE

(X6) DATE

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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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 13, 2026, 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 information: (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 the registered nurse (RN) documented training and competencies for two of two unlicensed personnel ((ULP)-A, ULP-B). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on April 11, 2024, to provide direct care and services to the licensee's residents. On July 14, 2026, at 8:38 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's 30-day Training and Competency Evaluation for DSPs/ULPs dated April 18, 2024, lacked the following required documentation for each of the competency evaluations: - facility name, location, and license number; - the total amount of time of the training and competency evaluation; - name of the instructor and the name of the competency evaluator, if different from the instructor, with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. ULP-A's Educare Assisted Living Orientation Checklist - Caregiver dated April 17, 2024, indicated online users would attach a copy of their	0 650			

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0 650	Continued From page 5 transcript to demonstrate time and competency in a subject matter; DVD users would attach a copy of their knowledge assessment or certificate and attendance records to demonstrate time and competency in a subject matter; and a copy would be in the employee record. The orientation checklist indicated the regulatory requirements would be the following Educare courses provided online or by digital video disc (DVD) as indicated below: - Medication Administration Overview (medications, exercise, and treatment reminders); and - Client Mobility Exercise and Ambulation (medications, exercise, and treatment reminders). ULP-A's undated Educare transcript lacked training that included Medication Administration Overview and Client Mobility Exercise and Ambulation as indicated on ULP-A's Educare Assisted Living Orientation Checklist. ULP-A's records lacked evidence of documentation to support training related to medications, exercise, and treatment reminders. ULP-B ULP-B was hired on April 3, 2023, to provide direct care and services to the licensee's residents. ULP-B's 30-day Training and Competency Evaluation for DSPs/ULPs dated July 24, 2025, and September 13, 2023, lacked the following required documentation for each of the competency evaluations: - facility name, location, and license number; - the total amount of time of the training and competency evaluation; and	0 650			

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0 650	Continued From page 6 - name of the instructor and the name of the competency evaluator, if different from the instructor, with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. ULP-B's Educare Assisted Living Orientation Checklist - Caregiver dated April 3, 2023, indicated online users would attach a copy of their transcript to demonstrate time and competency in a subject matter; DVD users would attach a copy of their knowledge assessment or certificate and attendance records to demonstrate time and competency in a subject matter; and a copy would be in the employee record. The orientation checklist indicated the regulatory requirements would be the following Educare courses provided online or by digital video disc (DVD) as indicated below: - Falls Prevention (the preventions of falls for providers working with elderly or individuals at risk of falls); - Professional Boundaries (understanding appropriate boundaries between staff and residents and the resident's family); - Medication Administration Overview (medications, exercise, and treatment reminders); - Client Mobility Exercise and Ambulation (medications, exercise, and treatment reminders); and - Vital Signs (reading and recording temperature, pulse, and respirations of the resident). ULP-B's undated Educare transcript lacked	0 650			

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0 650	Continued From page 7 training that included Falls Prevention; Professional Boundaries; Medication Administration Overview; Client Mobility Exercise and Ambulation; and Vital Signs as indicated on ULP-A's Educare Assisted Living Orientation Checklist. ULP-B's records lacked evidence of documentation to support training related to the prevention of falls for providers working with elderly or individuals at risk of falls; medications, exercise, and treatment reminders; understanding appropriate boundaries between staff and residents and the resident's family; and reading and recording temperature, pulse, and respirations of the resident. On July 14, 2026, at 3:17 p.m., ULP-B stated they were trained by the nurse for training related to the prevention of falls for providers working with elderly or individuals at risk of falls; medications, exercise, and treatment reminders; understanding appropriate boundaries between staff and residents and the resident's family; and reading and recording temperature, pulse, and respirations of the resident. On July 14, 2026, at 3:28 p.m., human resource manager (HRM)-G indicated in an email that the staff had been trained on the prevention of falls for providers working with elderly or individuals at risk of falls and understanding appropriate boundaries between staff and residents and the resident's family. HRM-G indicated the training would have been recorded on the Educare Assisted Living Orientation Checklist. HRM-G indicated Educare transcripts do not cover all areas of training and Educare courses have changed throughout the years. HRM-G stated the licensee followed the Educare training	0 650			

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0 650	Continued From page 8 requirements for the Assisted Living licensing to stay in compliance. HRM-G indicated they could not explain why ULP-A had the Vital signs course through Educare on their transcript and ULP-B did not. HRM-G indicated vital signs were trained by the nurse when staff completed new hire orientation and not usually trained on Educare. HRM-G indicated the training for medication, treatment, and therapy reminders was not included in the licensee's task binder and was not indicated on either ULP-A or ULP-B's Educare transcripts. On July 15, 2026, at 11:47 a.m., clinical nurse supervisor (CNS)-D stated they taught ULP-A and ULP-B on medications, exercise, and treatment reminders; falls prevention; and professional boundaries verbally. CNS-D stated if the required training was indicated on the licensee's check list and indicated the training was through Educare, then it should have been on the Educare transcript. The licensee's Personnel Records policy dated February 5, 2026, indicated the personnel records would include record of all required training and competency evaluations for unlicensed personnel. Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom	0 650			

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0 650	Continued From page 9 style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - 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 - name and title of the staff person completing the training, and the staff person's signature with a 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			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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	0 680			

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0 680	Continued From page 10 (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 observation, 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 residents receiving services under the provisional assisted living license. 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). The findings include: The licensee's undated EPP lacked the following required content: -process for emergency preparedness collaboration; -policies and procedures for subsistence needs for staff and residents;	0 680			

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0 680	Continued From page 11 -policies and procedures for tracking of staff and residents; -policies and procedures for medical documents; -policies and procedures for volunteers; -policies and procedures for arrangements with other facilities; -policies and procedures for roles under a waiver declared by secretary; -names and contact information; -emergency officials contact information; -primary and alternate means for communication; -methods for sharing information; -EPP training program; and -emergency prep testing requirements. On July 15, 2026, at 8:48 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing content as noted above. CNS-D stated the EPP did not address substance needs for food, alternate sources of energy, or sewage/waste. CNS-D stated the EPP did not have a policy and procedure for the documentation of tracking staff and residents but had only briefly mentioned they would be tracked in the event of evacuation. CNS-D stated the EPP did not indicate a system of how medical documents would be protected to maintain security or what CFR 45 was in relation to the release of medical information in an emergency. CNS-D stated the EPP indicated the licensee would utilize volunteers but acknowledged the EPP did not indicate how the volunteers would be processed or registered in an emergency event. CNS-D stated the licensee did not have a written agreement for other facilities or transportation companies as indicated in the EPP that addressed how the continuity of care would be maintained. CNS-D stated the licensee owned other facilities that would be utilized. CNS-D acknowledged 911 or an ambulance would not be an appropriate plan for	0 680			

Minnesota Department of Health

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0 680	Continued From page 12 evacuation of residents during an emergency or disaster. CNS-D acknowledged the EPP did not include a policy and procedure that outlined the facilities role in care or treatments under section 1135 waiver during a declared public health emergency. CNS-D confirmed the communication plan in the EPP did not include contact information for all staff. CNS-D indicated the EPP did not have alternate contact information to provide a means for alternate communication. CNS-D stated the licensee did not have any documentation of an after-action analysis for testing drills of the EPP. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

Minnesota Department of Health

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0 775	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775			
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	01290			

Minnesota Department of Health

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01290	Continued From page 14 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the licensee's assisted living health facility identification (HFID) number for three of twenty-one unlicensed personnel ((ULP)-H, ULP-I, ULP-J). 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's Employee List dated July 13, 2026, for HFID 34562, indicated ULP-H, ULP-I, and ULKP-J were current employees of the licensee. ULP-H ULP-H was hired on March 21, 2024, to provide direct care and services to the licensee's residents.	01290			

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01290	Continued From page 15 On July 14, 2026, at 10:57 a.m., ULP-H stated they worked at multiple facilities owned by the licensee. ULP-H stated their job duties included medication administration; food preparation for residents; performed safety checks; and assisted residents with light housekeeping and laundry needs. ULP-H confirmed they had last worked at the facility on July 6, 2026; and they were scheduled to work at the facility again on July 20, 2026. On July 14, 2026, at 11:05 a.m., the Department of Human Services NETStudy2.0 website indicated ULP-H was separated from the licensee's HFID 34562 on April 15, 2024. ULP-I ULP-I was hired on April 3, 2023, to provide direct care and services to the licensee's residents. On July 14, 2026, at 11:05 a.m., the Department of Human Services NETStudy2.0 website indicated ULP-I was separated from the licensee's HFID 34562 on April 15, 2024. ULP-J ULP-J was hired on May 15, 2023, to provide direct care and services to the licensee's residents. On July 14, 2026, at 11:05 a.m., the Department of Human Services NETStudy2.0 website indicated ULP-J was separated from the licensee's HFID 34562 on April 15, 2024. On July 14, 2026, at 3:00 p.m., licensed assisted living director (LALD)-C stated the licensee was not aware of the employees not being affiliated to the licensee's HFID 34562, however the licensee understood they were still responsible to make	01290			

Minnesota Department of Health

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01290	Continued From page 16 sure the background studies were always current and up to date. On July 14, 2026, at 3:00 p.m., the surveyor requested a policy on conducting and handling background studies on employees, but the surveyor did not receive a policy. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP-A). 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	02320			

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02320	Continued From page 17 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on April 11, 2024. On July 14, 2026, at 8:38 a.m., ULP-A stated they had washed their hands prior to the surveyor's continuous observation of ULP-A with medication administration. ULP-A stated they would review medications in the computer to make sure all the medication rights were correct, but the surveyor did not observe ULP-A perform a medication review. ULP-A unlocked the medication cart and gathered a medication blister pack for resident (R2). ULP-A placed Benztropine 0.5 milligrams (mg) in a disposable medication cup and dated and initialed the back of the medication blister pack before putting it back in the medication cart. ULP-A grabbed a bottle of water, went to the door of R2's room, and knocked on the door. R2 yelled through the door, "it's my day off, just trying to sleep." ULP-A attempted to talk to R2 through the door to give the medication but R2 continued to refuse. ULP-A went back to the medication cart and placed the medications set up in the disposable cup inside of the medication cart and locked the cart. ULP-A stated they planned to document the refusal of the medication later. The surveyor did not observe ULP-A document the refusal of the medication. On July 14, 2026, at 9:05 a.m., the surveyor observed R2 come from downstairs where their room was located and stated they were now ready to take their medication. ULP-A got the medication that was preset up in the disposable medication cup from the locked medication cart and gave the medication to R2. ULP-A observed	02320			

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02320	Continued From page 18 R2 taking the medication. ULP-A then logged into the computer, gathered the medication blister pack out of the medication cart and verified the medication under the resident profile. ULP-A stated they were re-verifying the medication even though it was already administered. The surveyor observed the computer indicated benztropine was administered on July 14, 2026, at 7:57 a.m. ULP-A confirmed with the surveyor the medication was documented as given prior to the administration of the medication. ULP-A stated they usually did not document medications given prior to medication administration however they did that day since they knew it was going to be a busy day. ULP-A stated they were trained by the nurse to make sure the medication was the right time, right medication, and right dose; then provide the medication for administration; and document the administration after the medication is given. On July 15, 2026, at 7:53 a.m., during a continuous observation, the surveyor observed as ULP-A went to R1's room and asked R1 if they were ready for their medications. ULP-A went to the medication cart and logged into the licensee's computer; documented they provided a bathing reminder to R1, but this was not observed by the surveyor; viewed R1's medication list; got a disposable medication cup and removed R1's medications from the medication cart. ULP-A stated they do three checks. ULP-A dated and initialed the back of each medication bubble pack as they placed the medication in the disposable medication cup for vitamin D3, benztropine, and haloperidol. ULP-A then verified all medications. ULP-A gave the medication to R1 and observed the medication being administered. ULP-A stated they would document the medications administered after, but the surveyor did not	02320			

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02320	Continued From page 19 observe ULP-A document the administration. ULP-A stated they needed to do R3's medication administration next as R3 needed to go to work. ULP-A placed R1's medications back in the locked medication cart. ULP-A reviewed R3's medication list; and stated R3 takes two medications. ULP-A got a disposable medication cup and R3's medication bubble packs from the medication cart. ULP-A dated and initialed each medication on the medication bubble pack as they set up R3's medications. ULP-A noted a medication was on hold for R3. ULP-A gave the medications set up to R3 and observed R3 taking the medication. ULP-A put R3's medications back in the medication cart. The surveyor then observed ULP-A documented on the medication administration of R1's Vitamin D only. The surveyor noted ULP-A had difficulty with finding the area to document the medication administration in the computer. ULP-A stated they were not too good on the computer. ULP-A then went to R3's profile in the computer, reviewed R3's medication list and medication history but did not document the medication administration. ULP-A then went on the assignment area in the computer and charted on tasks for cleaning, dressing, bathing reminder, and meal preparation as ULP-A stated the resident had already eaten. ULP-A then went to R1's medication administration task on the computer and documented they re-verified the medications for vitamin D3, benztropine, and haloperidol; and then clicked completed to indicate all medications were administered. ULP-A stated R2 was not at the facility as R2 had left overnight but proceeded to document complete for medication administration on R2. ULP-A then proceeded to document they completed a safety check on a different resident (R4). ULP-A documented on R3's omeprazole and multivitamin as being	02320			

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02320	Continued From page 20 administered and then logged off computer. On July 15, 2026, at 8:21 a.m., clinical nurse supervisor (CNS)-D stated they had talked to ULP-A this morning about medication administration and documentation. CNS-D stated there were other things going on with groceries. CNS-D stated they told ULP-A to document after a resident took their medications despite other things going on; and explained the documentation is all they may have at times when the licensee needed to recreate a story based on the timing of medication administration. CNS-D stated the licensee had a resident in the hospital, but the staff had continued to document medication administration for that resident despite the resident not being at the facility. CNS-D stated they had talked to staff in the past as it is now part of the training; and stated the licensee gave ongoing reminders to staff. CNS-D confirmed the licensee had been using a new electronic record system to document resident care needs for the last two weeks, however they expected staff to reach out to the nurse with any issues with documentation. CNS-D stated they will need to re-teach on the process of medication documentation in the new system. The licensee's Documentation of Medication, Treatment and Therapy Management services policy dated January 5, 2026, indicated staff would document each task immediately after the task had been performed. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration dated January 3, 2022, indicated medication administration would be modeled on the six rights of medication safety that included right person, right medication, right dose, right	02320			

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02320	Continued From page 21 time, right route, and right documentation. The policy indicated the ULP would be trained as followed by these steps: - have the resident present when you are ready to administer medications; - open the medication administration record (MAR) within Eldermark System Point of Care (the licensee began using a different electronic record system (Rtask) two weeks prior to the initiation of survey) for the resident; - gather supplies needed to include water, medication cup, etc; - wash hands or use hand sanitizer; - identify and review all blister packs for the current medication pass against the MAR; - one at a time, pick up a blister pack, again comparing it to the medication on the MAR, and punch out the correct dose of medication into a medication cup. Turn the blister pack over and continue to repeat this step until all medication for the current medication pass have been placed in the medication cup; - turn all blister packs over, review of each medication with the MAR for a third time, and initial/date the back of the blister pack; - place blister packs behind resident's name in medication cart, close drawer and lock medication cart; - give the medication cup to the resident and observe while they swallow the medication; and - wash hands or use hand sanitizer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
SMC ASHTON INC , Parcel: Phone:	License: HFID 34562 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F7994261145 Inspection Type: Full - Single Date: 7/13/2026 Time: 12:27:59 PM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 1</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery: Emailed</u>

! New Order: 3-500B Microbial Control: hot and cold holding
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Fridge found at 45 F. All TCS foods were discarded by staff. Provide inspector with picture of correct temperature readings before restocking fridge with TCS foods.
Comply By: 7/13/2026 Originally Issued On: 7/13/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: Paper towel dispenser was found moved away from sink. Install a paper towel dispenser near the sink.
Comply By: 7/20/2026 Originally Issued On: 7/13/2026

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS COMPOSITE WOOD, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES:

Milk 45

Sliced Meats 45

Milk 44

HRD INSPECTOR: Rhawnie Quinehan

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7994261145 from 7/13/2026



Sheikh Dukuly

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F7994261145		Food Establishment Inspection Report		Page 1 of 1		
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		2	Date: 7/13/2026	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 12:27:59 PM	
		Score (optional)			Dur: min	
Establishment: SMC ASHTON INC		Address:		City/State: ,	Zip: 	Phone:
License/Permit #: HFID 34562		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation		
Compliance Status				COS	R	
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	IN	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	OUT	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	N/O	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	IN	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT 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	N/A	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/A	Plant food properly cooked for hot holding				
35	IN	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)				Follow-up: Follow-up Date:		

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34562016-0	Date: July 14, 2026
Facility Name: SMC Ashton Inc	
Facility Address: 7435 78 th Ct N, Brooklyn Park, MN 55445	

☒ TAG IDENTIFICATION: 0775	
SCOPE/ SEVERITY: Level 2; Widespread	TIME PERIOD OF CORRECTION: Two (2) days

1.

Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2.

Where smoking is permitted, suitable noncombustible ashtrays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: There was a cigarette butt receptacle on the back deck of the facility. The butt receptacle was plastic and was missing from the metal bucket insert. Maintenance (M)-F stated that they were not sure where the bucket went, but that they would replace it.