DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350793266M
Compliance #: HL350792566C

Date Concluded: July 14, 2026

Name, Address, and County of Licensee Investigated:
SMC Ashton Inc
6642 Dupont Avenue
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused the resident when the AP had sex with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. During a law enforcement investigation, sexually explicit text messages between the AP and the resident were found on the resident's cell phone. The AP admitted to having sexual intercourse with the resident on at least one occasion. The AP was arrested for criminal sexual assault.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident records, internal facility investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed interactions between staff and current resident.

The resident resided in an assisted living facility. The resident's diagnoses included antisocial personality disorder, major depression, anxiety, and substance abuse. The resident's service plan included assistance with medication management, behavioral management, meals, housekeeping, and laundry.

The internal investigation indicated the resident reported he and the AP had sexual intercourse multiple times throughout the past few months. Also, the resident reported he gave the AP $700 to $1,000 and borrowed her cigarettes. The AP denied she engaged in sexual acts or accepted money from the resident. Text messages on the resident's phone indicated the resident told the AP he loved her, and the AP texted the resident back "love u too." Facility staff who worked with the AP reported they did not observe inappropriate interactions between the AP and the resident and did not see the resident give the AP money. However, multiple staff reported the resident and AP often went outside together to smoke cigarettes. When the member of management met with the resident after his initial report, the resident showed more text messages sent by the AP. The text messages were sexually explicit and recounted the AP and the resident's engagement in sexual acts. Law enforcement contacted the facility and reported they also observed sexually explicit text messages between the AP and resident.

A law enforcement report indicated the resident said he had a sexual relationship with the AP. The resident reported he and the AP engaged in sexual acts four or five times over a few months. The resident provided text messages where him and the AP discussed having oral sex. Another text message sent from the AP to the resident indicated "I can't have sex with you again ever. It was never supposed to happen, but it did and now I'm ashamed and scared that you might tell on me." In another text message, the AP told the resident she loved him. The resident reported they had sexual intercourse in her vehicle one time, and the other times were in his bedroom. When law enforcement interviewed the AP, she initially denied she engaged in sexual acts with the resident but later admitted she had sexual intercourse with the resident one time in her car. She reported the resident wore a condom. The AP was arrested and charged with felony level criminal sexual conduct.

During an interview, the resident said he and the AP had sexual intercourse six times. They engaged in sexual acts in his bedroom (downstairs) and in her car. The resident engaged in fellatio with the AP twice. He reported the AP gave him alcohol more than once. He also reported the AP was in an abusive relationship and he gave her at least $1,000 so she could stay at hotels away from her abusive partner. He showed the police the sexually explicit text messages between them. He said he wanted his money back.

During an interview, a member of management said she completed the internal investigation. The resident reported he and the AP had sex in his bedroom multiple times. She observed text messages on the resident's phone that indicated a sexual relationship. The AP sent the resident text messages indicating what type of sex the AP would and would not perform. During the internal investigation, the AP denied she had sexual relations with the resident.

During an interview, an unlicensed personnel who worked with the AP said the AP and resident often went outside to smoke cigarettes together. She said they may have smoked in the resident's car at times. The resident's bedroom was downstairs. At times the AP was downstairs to do laundry and administer medication. She denied witnessing inappropriate sexual behaviors between the resident and the AP. She denied observing the resident give the AP money.

During an interview, the nurse said the AP worked for the facility for a couple years and received vulnerable adult maltreatment training upon hire and annually. After the incident, re-education on vulnerable adult maltreatment was completed with facility staff members.

The AP did not respond to interview requests.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: No. Never returned request for interview.

Action taken by facility:
The facility completed an internal investigation and reported the incident to law enforcement. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35079	A. BUILDING: _____ B. WING _____	C 06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	6642 DUPONT AVENUE BROOKLYN CENTER, MN 55430

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL350792566C/HL350793266M On June 12, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was one resident receiving services under the provider's Assisted Living license. The following correction order is issued for HL350792566C/HL350793266M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		