Electronically Delivered

June 21, 2024

Licensee
SMC Ashton Inc
3840 Boone Avenue North
New Hope, MN 55427

RE: Project Number(s) SL36009015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 30, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH NEW HOPE, MN 55427

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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: SL36009015 On May 28, 2024 through May 30, 2024 the Minnesota Department of Health conducted an pintail survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents receiving 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 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 May 28, 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 2 (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 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's missing resident policy was reviewed at least quarterly. This had the potential to affect all residents, staff, and any visitors of the facility. 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	0 680		

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0 680	Continued From page 3 or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Missing Resident policy reviewed on January 3, 2022, lacked documentation the policy had been reviewed quarterly. On May 30, 2024, at 3:30 p.m., licensed assisted living director (LALD)-A stated the missing resident plan was not reviewed quarterly and was an oversight on his part. The licensee's Missing Resident policy reviewed January 3, 2022, indicated the LALD and clinical nurse supervisor (CNS) will review the missing resident plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 4 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 780		

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0 780	Continued From page 5 Findings include: On a facility tour on May 28, 2024, with licensed assisted living director (LALD)-A, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD-A tested the smoke alarms in the bedrooms and could not be heard throughout the facility. The smoke alarms in the bedrooms are different smoke alarms than the smoke alarms throughout the rest of the facility. The smoke alarms in the bedrooms are battery powered and the smoke alarms throughout the rest of the facility are on a Bluetooth system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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0 790	Continued From page 6 by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 28, 2024, survey staff conducted a facility tour with licensed assisted living director (LALD)-A, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 7 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 May 28, 2024, survey staff toured the facility with licensed assisted living director (LALD)-A, and observed the following maintenance issues: 1. A hole in the wall by the front entrance door. 2. Wood fence in the backyard was deteriorating and falling due to lack of maintenance. 3. Garage was full of clutter and used for storage. 4. Carpet on the stairs going down to the basement was heavily stained. 5. Bedroom #5 had water stains on the ceiling tiles. 6. Main floor bathroom vanity door finish was peeled off.	0 800		

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0 800	Continued From page 8 7. All the walls throughout this facility are stained and soiled and could use a good cleaning and fresh paint. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650		

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01650	Continued From page 9 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included major depressive disorder, diabetes, and paranoid schizophrenia (mental health disorder). R1's service plan dated October 28, 2023, indicated the resident received services to include medication administration (including assistance with insulin injections), assistance with dressing, grooming, bathing, laundry, and housekeeping. R1's prescriber orders dated November 21, 2023, included an order for blood glucose monitoring two times per day. R1's electronic medication administration record dated May 1, 2024, through May 31, 2024, included the following: -Blood sugar - test blood sugar twice daily.	01650		

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01650	Continued From page 10 On May 29, 2024, at 7:30 a.m., surveyor observed unlicensed personnel (ULP)-D administer R1's morning medications and perform blood glucose monitoring. R1's service plan dated October 28, 2023, lacked the service of blood glucose monitoring and frequency of the service. Additionally, the service plan lacked the methods of monitoring assessments of the resident. On May 30, 2024, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated she just learned the method of monitoring resident assessments was not included on the service plans, and the same service plan was used for all residents. CNS-B stated she thought blood glucose monitoring for R1 was on the service plan, and it must have gotten missed. The licensee's NUR 8.0 Contents of Service Plans policy reviewed on January 3, 2022, indicated the service plan would include, a description of the services provided, fees for services, frequency of each service according to resident assessment and resident preferences, and schedule and methods of monitoring assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 11 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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 resident-specific instructions for medications for one of one resident (R1) whose medication administration was delegated to unlicensed personnel (ULP). 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: R1's diagnoses included major depressive disorder, diabetes, and paranoid schizophrenia (mental health disorder). R1's service plan dated October 28, 2023, indicated the resident received services to include medication administration, assistance with	01750		

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01750	Continued From page 12 dressing, grooming, bathing, laundry, and housekeeping. On May 29, 2024, at 7:35 a.m., surveyor observed ULP-D administer R1's scheduled morning medications. R1's electronic medication administration record (EMAR), dated May 1, 2024, through May 31, 2024, included the following: -atorvastatin 40 milligram (mg) daily; -test blood sugar twice daily; -escitalopram 10 mg daily; -gabapentin 300 mg three times daily; -Humalog Kwik insulin pen 100 units/milliliter (ml). Inject 8 units subcutaneous three times a day before meals; -Lantus Solostar insulin pen 100 units/ml. Inject 34 units subcutaneous daily; -losartan potassium 50 mg daily; -metformin 1000 mg twice daily; -olanzapine 20 mg twice daily; -prazosin hydrochloric acid 2 mg daily; -Pulmicort inhaler 90 micrograms(mcg) daily. Inhale 1 puff by mouth twice daily; -Trulicity injectable 0.75 mg/0.5 ml. Inject 0.5 ml (0.75 mg) subcutaneous every week; -varenicline tartrate 1 mg twice daily; and -Ventolin HFA (albuterol sulfate inhalation aerosol). Inhale 1-2 puffs into the lungs every four hours as needed for wheezing. The licensee failed to provide resident-specific instructions pertaining to the following as needed wheezing medication (parameters for dose needed): -Ventolin HFA (albuterol sulfate inhalation aerosol). Inhale 1-2 puffs into the lungs every four hours as needed for wheezing.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH 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
01750	Continued From page 13 On May 30, 2024, at 10:42 a.m., clinical nurse supervisor (CNS-B) stated the Ventolin inhaler lacked specific instruction and will have the provider clarify the order. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy reviewed January 3, 2022, indicated the RN will provide specific instructions for administering as needed (PRN) medications, treatment, and therapy consistent with the prescriber's prescription for the reason/circumstance under the PRN's may be administered. The RN will provide detailed instructions on the use of the PRN medication, therapy, or therapy as per prescriber orders. The licensee's HRM-2 - Delegation of Nursing Tasks policy reviewed January 3, 2022, indicated the RN may delegate medication administration to ULP only after the RN has developed specific written instructions for each resident and documented those instructions in the resident's medication record (MAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH NEW HOPE, MN 55427

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01890	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates 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). The findings include: On May 28, 2024, at 1:05 p.m., the surveyor observed medication cart with registered nurse (RN)-E. RN-E confirmed the following: -R1's opened Humalog Kwik insulin pen and Lantus Solostar insulin pen (fast acting insulins) lacked the date the insulin pens had been opened and when the insulin pens would expire. On May 30, 2024, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated time sensitive medications, such as insulins should have been labeled with open and expiration dates and staff are trained on this. The manufacturer's instructions for Humalog Kwik insulin pen dated March 2020, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Lantus	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH 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
01890	Continued From page 15 Solostar insulin pen dated June 2022, indicated to throw away 28 days after opened, even if it still has insulin in it. The licensee's Storage of Medication policy reviewed on January 3, 2022, indicated a drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drugs, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH 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
01940	Continued From page 16 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment or therapy management plan for blood glucose monitoring with the required content 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). The findings include: On May 28, 2024, at 12:35 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to the residents.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH 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
01940	Continued From page 17 R1's diagnoses included major depressive disorder, diabetes, and paranoid schizophrenia (mental health disorder). R1's service plan dated October 28, 2023, indicated the resident received services to include medication administration (including assistance with insulin injections), assistance with dressing, grooming, bathing, laundry, and housekeeping. R1's prescriber orders dated November 21, 2023, included an order for blood glucose monitoring two times per day. R1's electronic medication administration record dated May 1, 2024, through May 31, 2024, included the following: -Blood sugar - test blood sugar twice daily. On May 29, 2024, at 7:30 a.m., surveyor observed unlicensed personnel (ULP)-D administer R1's morning medications and perform blood glucose monitoring. R1's record lacked evidence of an individualized treatment or therapy management plan to include the following for assistance with blood sugars: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administered - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying an registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH NEW HOPE, MN 55427

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01940	Continued From page 18 administered as prescribed; and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 30, 2024, at 10:44 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the requirements of the treatment and therapy management plans and had not developed one for R1's blood glucose monitoring. The licensee's Resident Pre-Admission Assessment and Monitoring Process-Nursing, reviewed January 3, 2022, indicated the RN will evaluate the resident's treatments, if any and complete the treatment and therapy management plan if the organization provides services related to the resident's treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	3840 BOONE AVENUE NORTH NEW HOPE, MN 55427

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01950	Continued From page 19 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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 resident specific instructions for a treatment for one of one resident (R1) whose treatment administration was delegated to unlicensed personnel (ULP). 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: R1's diagnoses included major depressive disorder, diabetes, and paranoid schizophrenia (mental health disorder). R1's service plan dated October 28, 2023, indicated the resident received services to include medication administration (including assistance with insulin injections), assistance with dressing, grooming, bathing, laundry, and housekeeping. R1's prescriber orders dated November 21, 2023, included an order for blood glucose monitoring	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 20 two times per day. On May 29, 2024, at 7:30 a.m., surveyor observed ULP-D administer R1's morning medications and perform blood glucose monitoring. ULP-D stated there were no specific directions on the electronic medication administration record (EMAR), but if it was high or low, she would notify the RN. R1's EMAR record dated May 1, 2024, through May 31, 2024, included the following: -Blood sugar - test blood sugar twice daily. The licensee failed to provide resident specific instructions for blood glucose parameters of when to notify RN for the following treatment: -Blood sugar - test blood sugar twice daily. On May 30, 2024, at 10:46 a.m., clinical nurse supervisor (CNS)-B stated there should be parameters with the blood glucose monitoring on the EMAR and when to call the RN. The licensee's NUR 4.0- Delegation of Nursing Tasks policy reviewed January 3, 2022, indicated when a treatment or therapy is delegated or assigned to ULP, the RN or authorized licensed health professional must develop written specific instructions for each resident and document these instructions in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *05/28/24*
Time: 12:21:38
Report: 7994241097

Food and Beverage Establishment Inspection Report

Location:

Ashton Homes Llc
3840 Boone Avenue North
New Hope, MN55427
Hennepin County, 27

Establishment Info:

ID #: 0037753
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637771059
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.

BACON FOUND STORED ON TOP OF CONTAINERS OF READY TO EAT FOODS IN FRIDGE. EGGS FOUND STORED ON TOP OF FRIDGE. ASKED STAFF TO MOVE THESE ITEMS TO THE BOTTOM OF THE FRIDGE.

Comply By: 05/28/24

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

CURRENTLY FACILITY DOES NOT HAVE A WAY TO MEASURE THE INTERNAL TEMPERATURE OF THEIR DISHWASHER. INSPECTOR LEFT TWO TEST STRIPS WITH FACILITY AND THEY WILL EMAIL PICTURES ONCE THE CYCLE IS RUN.

Comply By: 05/28/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO APPROVED SOAP DISPENSER AT THE HANDWASH SINK.

Comply By: 05/28/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

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.

HANDWASH SINK DOES NOT HAVE A SUPPLY OF PAPER TOWELS.

Comply By: 05/28/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM WAS FOUND ON SITE. PROVIDED LINKS VIA EMAIL.

Comply By: 05/28/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

CURRENTLY HAND WASH SINK IS NOT INDICATED AS DESCRIBED ABOVE.

Comply By: 05/28/24

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

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 HARDWOOD, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND SMOOTH TEXTURED 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 38
BACON 38

Type: Full
Date: *05/28/24*
Time: 12:21:38
Report: 7994241097
Ashton Homes Llc

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994241097 of 05/28/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

Sheikh K Dukuly II
Director

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241097

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/28/24
Time In 12:21:38
Time Out

Ashton Homes Llc	**Address** 3840 Boone Avenue North	**City/State** New Hope, MN	**Zip Code** 55427	**Telephone** 7637771059
License/Permit # 0037753	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	(OUT)	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" 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	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 05/28/24

Inspector (Signature) Crystal Elva