Electronically Delivered

June 9, 2026

Licensee
1 On 1 Comprehensive Healthcare Solution LLC
1467 95th Place North
Maple Grove, MN 55369

RE: Project Number(s) SL39571016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 6, 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 . . ."

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39571	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1 ON 1 COMPREHENSIVE HEALTHCARE SOLL	1467 95TH PLACE NORTH MAPLE GROVE, MN 55369

(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: SL39571016-0 On May 4, 2026, through May 6, 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 have a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all 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	0 680		

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0 680	Continued From page 2 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: On May 4, 2026, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided the surveyor with the licensee's EPP last reviewed on April 29, 2025. The licensee EPP lacked the following required content: - EPP program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for volunteers; - arrangement with other facilities; - sharing information on occupancy/needs; and - LTC family notifications. On May 4, 2026, at 2:30 p.m., CNS/LALD-A stated their EPP lacked required content indicated above. CNS/LALD-A also stated they had updated their EPP as per the review date signed on, and that it needed more work to meet requirements. The licensee's Emergency Preparedness Plan policy dated March 21, 2026, indicated the [licensee] will have a written, facility-specific emergency preparedness plan for each of its four licensed facilities to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. A separate plan will be maintained and prominently posted for each licensed facility. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents.	0 680		

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0 680	Continued From page 3 Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan 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 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=C	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: (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	0 780		

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0 780	Continued From page 4 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, 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 one violation (a violation that will cause only minimal impact on the resident and does not affect 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, Physical Environment Inspection Report (PEIR) dated May 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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01500	Continued From page 5	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 6 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment that included the required annual training content for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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:	01500		

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01500	Continued From page 7 ULP-B ULP-B started employment with the licensee on January 1, 2025, to provide assisted living services. On May 5, 2026, at 8:00 a.m., the surveyor observed ULP-B administer medications to R4 in their room. ULP-B's Transcript dated November 2, 2025, indicated ULP-B had completed annual training in the following topics for a total of three hours: - reporting maltreatment of vulnerable adults or minors - 0.75 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1 hour; and - principles of person-centered planning/service delivery - 0.5 hours. ULP-C ULP-C started employment with the licensee on November 10, 2023, to provide assisted living services. ULP-C's Transcript dated September 28, 2025, indicated ULP-C had completed annual training in the following topics for a total of three hours: - reporting maltreatment of vulnerable adults or minors - 0.75 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1 hour; and - principles of person-centered planning/service delivery - 0.5 hours. ULP-D ULP-D started employment with the licensee on December 17, 2024, to provide assisted living services.	01500		

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01500	Continued From page 8 On May 5, 2026, at 8:55 a.m., the surveyor observed ULP-D assist to transfer, and check and change R3 in their room. ULP-D's Transcript dated November 7, 2025, indicated ULP-D had completed annual training in the following topics for a total of three hours: - reporting maltreatment of vulnerable adults or minors - 0.75 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1 hour; and - principles of person-centered planning/service delivery - 0.50 hours. ULP-B, ULP-C, and ULP-D's record lacked the following required annual training topics: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of provider's policies and procedures. On May 5, 2026, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they may have not assigned the missing topics. CNS/LALD-A also stated they would check their Educare (training software) to assign them. The licensee's Staff Orientation and Education policy dated March 21, 2026, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment on the following topics: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff responsibilities - review of the organization's policies and	01500		

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01500	Continued From page 9 procedures and how to implement them - infection control techniques including implementation of CDC standards; hand washing; PPE use; appropriate disposal of contaminated materials; disinfection of reusable equipment and environmental surfaces; reporting of communicable diseases; - effective approaches to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's disease or related disorders; and - the principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the	01620		

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01620	Continued From page 10 resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for three of three residents (R1, R2, R3).	01620		

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01620	Continued From page 11 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: R1 R1 was admitted to the licensee on February 15, 2024, and began receiving assisted living services. R1's diagnoses included essential hypertension, abdominal distension (gaseous), abnormal weight gain, and cerebral infarction without residual deficit. R1's Service Plan (Waiver) - Addendum to Contract dated January 11, 2026, indicated R1 received the following services: activity assistance, bathing assistance, dressing, escort, grooming, housekeeping, laundry, manage behavior, medication administration, assessment and monitoring. R1's record included three ongoing resident assessments dated August 21, 2025, November 22, 2025, and February 22, 2026. R1's assessments dated November 22, 2025, and February 22, 2026, indicated 93 days and 92 days had passed between the assessments, respectively. R2	01620		

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01620	Continued From page 12 R2 was admitted to the licensee on November 5, 2025, and began receiving assisted living services. R2's diagnoses included essential hypertension, borderline personality disorder, type 2 diabetes mellitus without complications, and generalized anxiety disorder. R2's Service Plan (Waiver) - Addendum to Contract dated November 5, 2025, indicated R2 received the following services: appointment reminder, bathing assistance, dressing, grooming, housekeeping, laundry, manage behavior, medication administration, and assessment and monitoring. R2's record included a 14-day reassessment completed on November 22, 2025, and two ongoing resident assessments dated February 22, 2026, and April 8, 2026. R2's assessments dated November 22, 2025, and February 22, 2026, indicated 92 days had passed between the assessments. R3 R3 was admitted to the licensee on May 8, 2024, and began receiving assisted living services. R3's diagnoses included essential hypertension, paranoid schizophrenia, traumatic brain injury without loss of consciousness, and difficulty walking. R3's Service Plan (Waiver) - Addendum to Contract dated January 14, 2026, indicated R3 received the following services: appointment reminder, dressing, grooming, housekeeping, laundry, manage behavior, medication setup, and assessment and monitoring.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39571	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1 ON 1 COMPREHENSIVE HEALTHCARE SOLL	1467 95TH PLACE NORTH MAPLE GROVE, MN 55369

(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
01620	Continued From page 13 R3's record included 90-day assessments completed on August 21, 2025, November 22, 2025, and February 22, 2026. R3's assessments dated November 22, 2025, and February 22, 2026, indicated 93 days and 92 days had passed between the assessments, respectively. On May 6, 2026, at 4:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware the resident assessments were completed late. CNS/LALD-A also stated they scheduled all resident assessments by day 90 and that they made sure they were done as per schedule. The licensee's Assessment and Reassessment policy dated March 21, 2026, indicated registered nurse (RN) will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. The policy also indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Establishment Info

1 ON 1 COMPREHENSIVE HEALTHCAR
14967 95TH PLACE NORTH
Maple Grove, MN 55369
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39571

Risk:
License:
Expires on:
CFPM: KARLU DORLEH
CFPM #: FM17603; Exp: 11/17/2028

Inspection Info

Report Number: F8087261101
Inspection Type: Full - Single
Date: 5/5/2026 Time: 3:30:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT
FLOORS: TILE - COMPLIANT
COUNTERTOPS: LAMINATE - NON COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: GE
DISHWASHER: WHIRLPOOL
STOVE/RANGE: GE
HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT COUNTERTOP AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE STRIPS USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR BENARD NYANGENA.

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 F8087261101 from 5/5/2026

John Boettcher

KARLU DORLEH
OWNER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

1 ON 1 COMPREHENSIVE HEALTHCAR
Maple Grove
County/Group: Hennepin County

Inspection Info

Report Number: F8087261101
Inspection Type: Full
Date: 5/5/2026
Time: 3:30:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at -4 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39571016-0	**Date:** 5/6/2026
Facility Name: 1 ON 1 COMPREHENSIVE HEALTHCARE	
Facility Address: 14967 95TH PLACE NORTH MAPLE GROVE, MN 55369	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: The lower-level hallway smoke detector was in the middle of the living room and not in the immediate vicinity of the sleeping rooms.