Electronically Delivered

April 8, 2026

Licensee
A1 Quality Living LLC
2407 Lyndale Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL41939015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 17, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

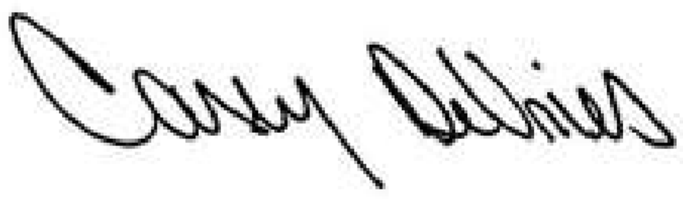
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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: SL41939015-0 On March 16, 2026, through March 17, 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 all of whom received services under the Provisional 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 480	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 480	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 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 March 16, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 485	Continued From page 4 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, R2, and R3 were admitted to the licensee on November 3, 2025, and began receiving assisted living services. R1, R2, and R3's Resident Contract for Assisted Living signed on November 3, 2025, included the following on page 13: "This Assisted Living Facility offers all of the following (included in the Month Base Fee): - At least three meals daily with snacks available seven (7) days per week". The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On March 17, 2026, at 9:47 a.m., during an in-person interview with clinical nurse supervisor (CNS)-C and speaker phone interview with licensed assisted living director (LALD)-D, LALD-D stated the licensee received their templated contract from a consultant and they believed the consultant may have made an update to the templated contract to include the language to opt out for meals. LALD-D stated they would contact the consultant, pay a fee, and obtain the new templated contract. LALD-D stated they were aware of the requirement however, the licensee's current residents were on waivered services, and they were required to provide the residents with three meals and snacks daily. CNS-C stated they did not know the contract could not include meals as part of their	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 485	Continued From page 5 base fee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for one of four employees (unlicensed personnel (ULP)-B). 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 510	Continued From page 6 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 March 17, 2026, at 9:05 a.m., the surveyor observed ULP-B with gloves on prepare R2's oral medication, enter R2's room, administer R2's oral medication, document R2's medication administration in the electronic medication record (EMAR), and exit R2's room. Without glove removal or completing hand hygiene, ULP-B entered the medication closet, prepared R1's oral medication, retrieved a water bottle from the main level closet, entered R1's room, administered R1's oral medications, documented R1's medication administration on the EMAR, removed gloves, and then performed hand hygiene. On March 17, 2026, at 9:10 a.m., ULP-B stated they were trained to perform hand hygiene and apply gloves prior to medication administration, and to change gloves between residents. ULP-B stated they did not change their gloves in between R2 and R1 because they were nervous from the surveyor observing them. On March 17, 2026, at 10:02 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to wash their hands or use hand sanitizer between each medication pass or anytime they were soiled. The CDC's Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended hand hygiene should be performed: - immediately before touching a patient; - before performing an aseptic tasks;	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 510	Continued From page 7 - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or their surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's undated 8.09 Hand Washing policy indicated handwashing shall be completed: - before, during, and after preparing food; - before eating; - before and after caring for someone who is sick; - before and after treating a cut or wound; - after using the toilet; - after changing briefs or assisting someone who has used the toilet; - after blowing nose, coughing, or sneezing; - after touching animal waste; - after handling pet food or pet treats; and - after touching garbage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 680	Continued From page 8 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all 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). The findings include: The licensee's Emergency Preparedness and Fire Safety and Evacuation Manual revised 2025, indicated the licensee's primary location for evacuation was the licensee's address and the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 680	Continued From page 9 alternative evacuation site was another facility in the city of St. Paul. The licensee's primary evacuation site was not a valid evacuation site because it was the licensee's current address. In addition, the EPP also included a section titled important telephone numbers; the template was not filled in with names or phone numbers. The EPP lacked evidence of the following required content: - quarterly review of the missing resident plan; - subsistence needs for staff and residents; - alternative evacuation location; and - names and contact information. On March 16, 2026, at 2:07 p.m., during an in-person interview with owner (O)-E and speaker phone interview with licensed assisted living director (LALD)-D, LALD-D stated the missing resident plan should be completed quarterly however, the licensee had not conducted a review of the plan since they opened. LALD-D stated they would conduct a quarterly review when they returned from vacation. O-E stated the licensee attempted to get a memorandum of understanding (MOU) with another facility for being the site to evacuate to however, the other facility was not responding to their inquiry. O-E stated the licensee believed the primary and alternative evacuation sites needed to be at another group home. O-E verified the template of phone numbers were not filled in with information. O-E stated multiple staff members worked on the EPP and they were unable to complete this section. On March 17, 2026, approximately 10:15 a.m., O-E stated they added additional numbers to the EPP. No further information was provided.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 680	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 940	Continued From page 11 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for three of three residents (R1, R2, R3). 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 potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3 were admitted to the licensee on November 3, 2025, and began receiving assisted living services. R1, R2, and R3's Resident Contract for Assisted Living signed on November 3, 2025, included a section titled Statements Related to Public Assistance Programs and read, "You may be eligible to benefit from certain public assistance programs to assist in the payment of the Monthly Base Fee and/or other fees or charges. You are responsible for applying for these programs and for payment in full to us of amounts you owe pursuant to this Agreement, whether initial payments or fees billed on a monthly basis. Note that medical assistance waivers may provide payment for certain Assisted Living Services but do not cover the cost of rent; you may be eligible for assistance with rent though [sic] the housing	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 940	Continued From page 12 support program. The Community does not determine your eligibility for or acceptance into any public assistance program. The community does not require that residents pay privately for any specified period of time before becoming eligible to pay with public assistance funds. The community does not limit the number of people it is able to support using public funds. " The licensee's contract lacked the following required content: - whether the facility was enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility had and agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b). On March 17, 2026, at 9:58 a.m., during an in-person interview with clinical nurse supervisor (CNS)-C and speaker phone interview with licensed assisted living director (LALD)-D, LALD-D stated the licensee accepted elderly waiver, community access for disability inclusion (CADI) waiver, brain injury waiver, and private pay. LALD-D stated the licensee did not have an agreement to provide housing support services. LALD-D stated they would add additional information to the section noted above about what the licensee accepted at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 970	Continued From page 13	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R3). 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 potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3 were admitted to the licensee on November 3, 2025, and began receiving assisted living services. R1, R2, and R3's Resident Contract for Assisted Living signed on November 3, 2025, included the following language indicating waivers of liability: "We are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us."	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
0 970	Continued From page 14 On March 17, 2026, at 9:54 a.m., during an in-person interview with clinical nurse supervisor (CNS)-C and speaker phone interview with licensed assisted living director (LALD)-D, LALD-D stated they were aware the contract could not include waivers of liability. LALD-D stated the licensee received their templated contract from a consultant and they believed the consultant may have made an update to the templated contract to remove language that waived liability. LALD-D stated they would contact the consultant, pay a fee, and obtain a new templated contract for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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 15 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 a resident reassessment no more than 14 calendar days after initiation of services for two of three residents (R2, R3) and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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 16 failed to complete ongoing resident reassessments that did not exceed 90 days for two of three residents (R1, R3). 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 November 3, 2025, and began receiving assisted living services. R1's diagnoses included acute respiratory failure with hypoxia, adult failure to thrive, alcohol abuse, bipolar disorder (mental health condition characterized by significant mood swings), chronic obstructive pulmonary disease (COPD), delusional disorder, and intentional self-harm. R1's Service Plan - Modification signed November 3, 2025, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, housekeeping, behavior management, dressing, grooming, laundry, meals, medication administration, oxygen management, vital sign monitoring, safety checks, shopping, toileting, and transfers. R1's medical record included a 14-day assessment completed November 12, 2025, and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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 17 a 90-day ongoing assessment completed February 22, 2026, which indicated 102 days passed between the assessments. R2 R2 was admitted to the licensee on November 3, 2025, and began receiving assisted living services. R2's diagnoses included anxiety disorder, bipolar, depression, and restless leg syndrome. R2's Service Plan - Modification signed November 3, 2025, indicated R2 received assistance with activities, ambulation, appointments, transportation, bathing reminders, repositioning, housekeeping, behavior monitoring, dressing, grooming, laundry, meals, medication administration, nail care, vital sign monitoring, safety checks, shopping, toileting, and transfers. R2's record included an admission assessment completed on November 3, 2025, and a 14-day assessment completed on December 4, 2025, which indicated the 14-day assessment was completed 31 days after R2's admission. R3 R3 was admitted to the licensee on November 3, 2025, and began receiving assisted living services. R3's diagnoses included alcohol dependence with withdrawal, anxiety disorder, and depression. R3's Service Plan - Modification signed November 3, 2025, indicated R3 received assistance with activities, ambulation, appointments, transportation, bathing, repositioning, housekeeping, behavior	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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 18 management, dressing, mobility, grooming, laundry, meals, medication administration, nail care, vital sign monitoring, safety check, shopping, toileting, and transfers. R3's record included an admission assessment completed on November 3, 2025, a 14-day assessment completed on December 4, 2025, and ongoing assessment completed March 16, 2026, (during the survey). R3's 14-day assessment was complete 31 days after R3's admission, and R3's ongoing assessment was completed 102 days after the previous assessment. On March 17, 2026, at 10:04 a.m., clinical nurse supervisor (CNS)-C stated the licensee conducted preadmission, admission, 14-day, and 90-day assessments. CNS-C stated some resident assessments were completed late due to the resident being out of the facility. CNS-C stated R3 left the facility frequently or was intoxicated so R3's assessments were not able to be completed on time. CNS-C stated R2's assessments may have been late due to R2 leaving the facility for a leave of absence or appointments. CNS-C stated they did not know why R1's assessment would be late. The surveyor inquired if they had documentation on the attempts to complete the assessments. CNS-C stated they did not have documentation on the attempts to complete the assessment and it was their fault for not documenting the attempts made. The licensee's Assessment and Reassessment policy dated January 19, 2026, indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after the initiation of services. In	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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 19 addition, 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		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
01650	Continued From page 20 chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3). 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: R1 R1 was admitted to the licensee on November 3, 2025, and began receiving assisted living services. R1's Service Plan - Modification signed November 3, 2025, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, housekeeping, behavior management, dressing, grooming, laundry, meals, medication administration, oxygen management, vital sign monitoring, safety checks, shopping, toileting, and transfers. R2 R2 was admitted to the licensee on November 3, 2025, and began receiving assisted living services.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
01650	Continued From page 21 R2's Service Plan - Modification signed November 3, 2025, indicated R2 received assistance with activities, ambulation, appointments, transportation, bathing reminders, repositioning, housekeeping, behavior monitoring, dressing, grooming, laundry, meals, medication administration, nail care, vital sign monitoring, safety checks, shopping, toileting, and transfers. R3 R3 was admitted to the licensee on November 3, 2025, and began receiving assisted living services. R3's Service Plan - Modification signed November 3, 2025, indicated R3 received assistance with activities, ambulation, appointments, transportation, bathing, repositioning, housekeeping, behavior management, dressing, mobility, grooming, laundry, meals, medication administration, nail care, vital sign monitoring, safety check, shopping, toileting, and transfers. R1, R2, and R3's service plans lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included the action to be taken if the scheduled service could not be provided. On March 17, 2026, at 10:11 a.m., clinical nurse supervisor (CNS)-C stated the service plan listed all of the services provided for the resident and was signed yearly or with change in service. CNS-C stated they believed the service plans	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41939	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 QUALITY LIVING LLC	2407 LYNDALE AVE N MINNEAPOLIS, MN 55411

(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
01650	Continued From page 22 might lack information however, they thought if they printed out specific assessments or plans and placed them into the medical record it would cover what was needed. The surveyor reviewed the statute with CNS-C and CNS-C stated they were not aware of the required content listed above. The licensee's Service Plan policy dated January 19, 2026, indicated the service plan would include the following: - a description of the services, including medication management services to be provided; - the fees for service and the frequency of each service according to the resident current review or assessment and preferences; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessment of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that included actions to be taken if the scheduled service could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

A1 QUALITY LIVING LLC
2407 Lyndale Ave North
Mineapolis, MN
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41939

Risk:
License:
Expires on:
CFPM: ABDULATIF H ABDULRAHMAN
CFPM #: 124766; Exp: 07/26/2027

Inspection Info

Report Number: F1062261053
Inspection Type: Full - Single
Date: 3/16/2026 Time: 11:00 am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED RAW SHELL EGGS STORED ABOVE READY TO EAT FOODS SUCH AS PRODUCE AND CHEESE IN REFRIGERATOR. ENSURE THAT RAW ANIMAL PROTEINS ARE STORED BELOW READY-TO-EAT FOODS IN ORDER TO MINIMIZE THE RISK OF CONTAMINATION.

Comply By: 3/16/2026 Originally Issued On: 3/16/2026

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: OBSERVED DRYING RACK AND KITCHEN UTENSILS PLACED IN HANDWASHING SIDE OF 2 BASIN SINK DURING INSPECTION. ENSURE THE DESIGNATED HANDWASHING BASIN IS USED ONLY FOR HANDWASHING.

Comply By: 3/16/2026 Originally Issued On: 3/16/2026

Food & Beverage General Comment

INSPECTION COMPLETED ON BEHALF OF ASHLEY CREWS (MDH).

KITCHEN FEATURES 2 BASIN SINK (RIGHT BASIN IS HANDWASH SINK), QUARTZ COUNTERTOPS, TILE FLOORS, TILE BACKSPLASH OVER WALLS, RESIDENTIAL DISHWASHER

DISCUSSED MINIMUM AND MAXIMUM SANITIZER CONCENTRATIONS, PROHIBITIONS AGAINST SERVING LEFTOVERS, SEPARATION OF RAW ANIMAL PROTEINS FROM READY-TO-EAT FOODS, AND HANDWASHING SINK ACCESSIBILITY.

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 F1062261053 from 3/16/2026

Dilbi Hussein
PIC

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

A1 QUALITY LIVING LLC
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1062261053
Inspection Type: Full
Date: 3/16/2026
Time: 11:00 am

Food Temperature: Product/Item/Unit: POTATO SALAD**; Temperature Process:** Cold-Holding
Location: FRIDGE/FREEZER UNIT at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: WHOLE MILK**; Temperature Process:** Cold-Holding
Location: FRIDGE/FREEZER UNIT at 37 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

A1 QUALITY LIVING LLC
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1062261053
Inspection Type: Full
Date: 3/16/2026
Time: 11:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 167 Degrees F.
Comment: FACILITY KEEPS DAILY LOG OF TEMPERATURES
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No