STATE LICENSING COMPLIANCE REPORT

Report #: HL419399003C

Date Concluded: April 21, 2026

Name, Address, and County of Facility Investigated:
A1 Quality Living LLC
338 Aurora Avenue
St. Paul, MN 55193
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

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 _____	C 03/24/2026

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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL419399003C On March 24, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL419399003C, tag identification 2380.	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.	
02380 SS=F	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy,	02380		

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02380	Continued From page 1 initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect a resident's individual autonomy to make life choices by not allowing the resident the right to choose where they wanted to live for four of four residents (R1, R2, R3, R4). The licensee never asked the residents where they wanted to live or if they wanted to move facilities. 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: An email dated October 24, 2025, sent by owner (OW)-A to R1, R3 and R4's case manager, indicated the new landlord terminated the licensees' lease (of HFID 40720) effective November 30, 2025. OW-A spoke to R1, R3 and R4. R1, R3 and R4 agreed to move to a new facility (HFID 41939) where OW-A would continue to be the licensed assisted living director. The transition process would begin as soon as possible. R1, R2, R3, and R4's progress notes dated November 3, 2025, indicated the residents were	02380		

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02380	Continued From page 2 discharged from the previous licensee on November 3, 2025. This was the only documentation regarding discharge in the resident's medical records. Their medical records lacked documentation alternate housing options were offered to R1, R2, R3, and R4. R1 admitted to the licensee November 3, 2025. R1's service plan dated November 3, 2025, indicated R1 received services including assistance with medication management, behavioral management, meals, housekeeping, and reminders. R2 admitted to the licensee November 3, 2025. R2's diagnoses included schizophrenia and an eating disorder. R2's service plan dated November 3, 2025, indicated R2 received services including assistance with grooming, dressing, medication management, behavioral management, housekeeping, and reminders. R3 admitted to the licensee November 3, 2025. R3's diagnoses included bipolar disorder, adult failure to thrive, and alcohol abuse. R3's service plan dated November 3, 2025, indicated R3 received services including assistance with grooming, dressing, medication management, behavioral management, housekeeping, and reminders. R4 admitted to the licensee November 3, 2025. R4's diagnoses included bipolar disorder, anxiety disorder, and depression. R4's service plan dated November 3, 2025, indicated R4 received services including	02380		

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02380	Continued From page 3 assistance with medication management, dressing, bathing reminders, housekeeping, and behavioral management. On March 18, 2025, at 2:15 p.m., OW-B, co-owner of HFID 40720, said the previous landlord planned to sell the house. OW-B's relative purchased the house so the licensee could remain open. While OW-B was on vacation, OW-A moved the residents and staff to a new location without informing him. OW-B said the residents never complained about the facility [HFID 40720] or expressed they wanted to move. He said the residents could have remained at the facility. On March 25, 2026, at 1:00 p.m., OW-A said he received a notice from the housing landlord their lease (from HFID 40720) was ending November 30, 2025. He moved the residents to another facility (HFID 41939) he owned a few miles away. He sent the case mangers an email informing them the residents must move based on the lease termination. He sent the emails to all four case mangers a week before they moved. OW-A said the staff also moved with the residents to the new location and were employed by A1 quality Living LLC now. He said he never offered the residents alternate housing options other than the A1 Quality Living LLC which he owned. On March 24, 2026, at 10:20 a.m., R2 said he liked living at [HFID 40720] but was told he had to move. He was not given any other housing options. He said he never heard of an Ombudsman. R2 was reluctant to answer questions and said he did not want to say something he was not supposed to say. On March 24, 2026, at 10:35 a.m., R3 said they	02380		

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02380	Continued From page 4 moved because the two owners at the previous facility did not get along. She was never asked if she wanted to move to a new facility. On April 3, 2026, at 1:45 p.m., the ombudsman who represents R1, R2, R3, and R4 said he received a closure notice (for HFID 40720) on December 3, 2025. He denied he received information about the residents moving to a new facility. He denied he was invited to a meeting to discuss discharge planning or resident preferences. OW-A provided a signed copy of the Minnesota Assisted Living Bill of Rights for R1, R2, R3, and R4. The document indicated residents have the right to participate in planning of their care and the right to include legal and designated representatives. Residents have the right to be told in advance and take an active part in decisions regarding changes in service and the right to individual autonomy, initiative and independence in making life choices. Time Period to Correct: Seven (7) Days	02380		