Electronically Delivered

March 26, 2026

Licensee
Bobby's House
9200 James Avenue North
Brooklyn Park, MN  55444

RE:  Project Number(s) SL34949016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 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.

**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 . . ."

**IMPOSITION OF FINES**

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(6), MDH may impose fine amounts of either

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

**St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00**
**St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**
**St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**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**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#34949016<br><br>On February 23, 2026, through February 26, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license.<br><br>On February 24, 2026, an immediate correction order was issued for tag identification 0495.<br><br>On February 26, 2026, the immediate correction order for tag identification 0495 was rescinded and an immediate correction order was issued for tag identification 0520.<br><br>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. | 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 License 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 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 surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 340 SS=F | 144G.30 Subd. 5 Correction orders<br><br>(a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.<br>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.<br>(c) By the correction order date, the facility must:<br>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed March 6, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.<br><br>This practice resulted in a level two violation (a | 0 340 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 340 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>On March 22, 2024, the licensee received an enforcement letter, with the results of the licensee's previous survey completed on March 6, 2024. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their survey results, or April 12, 2024.<br><br>On February 23, 2026, at approximately 3:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee lacked any documented plans of correction for the correction orders from the previous survey. LALD/CNS-A also stated she was not aware corrections to orders were to be documented.<br><br>The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following:<br>-identify how each order was corrected related to each individual client(s)/employee(s) identified in the order;<br>-identify how each order was corrected for all the provider's clients/employees identified in the order; and<br>-identify what changes to the provider's systems | 0 340 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 340 | Continued From page 3<br>and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 340 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 470 | Continued From page 4<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a current staffing schedule was posted as required, potentially affecting all the licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living facility license for a capacity of four residents and had a current census of three residents.<br><br>On February 23, 2026, at approximately 10:15 a.m., during a tour of the facility, the surveyor observed a posted staff schedule on a bulletin board located in the living room with the dates of June 1, 2025, through June 7, 2025. The licensee lacked a current posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location.<br><br>On February 23, 2026, at approximately 11:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged the staffing schedule was not current. | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 470 | Continued From page 5<br><br>LALD/CNS-A stated the licensee was working on the current schedule and had not updated the staff schedule yet.<br><br>The licensee's Staffing policy, dated August 1, 2021, indicated the licensee would post a current staff schedule in a central location of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 6<br><br>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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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 | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 7<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>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<br><br>(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. | 0 485 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents and failed to ensure the assisted living contract did not require any resident to include and pay for meals as part of their assisted living monthly base fee for one of one resident (R1).<br><br>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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 10:45 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided three meals daily to the residents.<br><br>MENU<br>On February 23, 2026, at approximately 11:15 a.m., during a facility tour of the kitchen and common areas, the surveyor did not observe a prepared menu that was available to all residents.<br><br>On February 23, 2026, at approximately 11:20 a.m., LALD/CNS-A acknowledged a menu was not available to all residents and stated the licensee currently did not have a menu because the residents change their preferences for food | 0 485 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 9<br>often and would tear down the menu if it was posted.<br><br>R2's CONTRACT<br>R2 was admitted on March 10, 2023.<br><br>R2's Assisted Living Contract, dated March 10, 2023, on page 4, indicated three meals per day were included in the basic monthly fee.<br><br>On February 23, 2026, at 2:50 p.m., LALD/CNS-A acknowledged the licensee's assisted living contract required residents to pay for meals as part of their base fee. LALD/CNS-A also stated the resident meals would need to be removed from the base fee.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 520 SS=F | 144G.41 Subd. 4 Clinical nurse supervision<br><br>All assisted living facilities must have a clinical nurse supervisor who is a registered nurse licensed in Minnesota.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the assisted living facility had a clinical nurse supervisor (CNS) who was a registered nurse (RN) licensed in Minnesota. This had the potential to affect all residents.<br><br>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 | 0 520 | During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 520 | Continued From page 10<br><br>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).<br><br>The findings include:<br><br>The licensee's Minnesota Department of Health (MDH) application for Assisted Living (AL) license, dated July 19, 2025, page two, indicated licensed assisted living (LALD)/CNS-A was the CNS for the licensee.<br><br>The Minnesota Board of Nursing website was accessed on February 23, 2025, at 8:55 a.m., indicated LALD/CNS-A's RN license had expired on January 31, 2026.<br><br>On February 23, 2026, at approximately 9:00 a.m., during the entrance phone call with the licensee, LALD/CNS-A stated she was the licensed RN supervisor that performed all the nursing tasks for the licensee.<br><br>The licensee held an assisted living facility license staffed with 10 personnel - LALD/CNS-A, RN-B, and eight unlicensed personnel (ULP). The licensee was licensed for a bed capacity of four residents and had a current census of three residents.<br><br>On February 23, 2026, at approximately 10:05 a.m., during a facility tour with unlicensed personnel (ULP)-C, ULP-C stated LALD/CNS-A would be the RN the ULPs would call first if the ULPs needed any support or consultation on resident services. ULP-C also stated RN-B is the back up RN for the licensee and worked only as | 0 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 520 | Continued From page 11<br>needed.<br><br>On February 23, 2026, at approximately 10:30 a.m., during the entrance conference, LALD/CNS-A stated the licensee employed two licensed RNs that included LALD/CNS-A and CNS-B. LALD/CNS-A also stated she was the licensed RN supervisor that performed all the nursing tasks for the licensee. LALD/CNS-A further stated the licensee had hired RN-B as a backup RN who worked for the licensee only as needed.<br><br>On February 23, 2026, at approximately 1:40 p.m., LALD/CNS-A provided the surveyor R1's one page document titled Discharge Summary, signed by LALD/CNS-A, dated February 14, 2026, that indicated LALD/CNS-A provided RN services with an expired RN license.<br><br>On February 23, 2026, at approximately 2:00 p.m., LALD/CNS-A provided the surveyor with the licensee's employee list. The licensee's employee list indicated two RNs that included LALD/CNS-A and RN-B.<br><br>LALD/CNS-A was hired March 15, 2015, as the full time RN to provide nursing services for the licensee.<br><br>LALD/CNS-A's employee record included a three-page document titled Job Description: Registered Nurse, signed by LALD/CNS-A, undated, indicated LALD/CNS-A read and understood the RN position qualifications that included a current and active license as a RN in the state of practice.<br><br>The Minnesota Board of Nursing website was accessed with LALD/CNS-A on February 23, | 0 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 520 | Continued From page 12<br><br>2025, at 3:00 p.m., and indicated LALD/CNS-A's RN license expired on January 31, 2026. LALD/CNS-A confirmed this finding.<br><br>On February 23, 2026, at approximately 3:05 p.m., LALD/CNS-A stated they were unaware the RN license was expired and was an oversight by LALD/CNS-A.<br><br>On February 24, 2026, at approximately 12:50 p.m., by phone interview with LALD/CNS-A, LALD/CNS-A stated RN-B works for the licensee on average one to two days a month as needed.<br><br>The licensee's Employment Process policy, undated, indicated the licensee would verify RN license renewals with the licensing board for RN staff of the licensee.<br><br>The licensee's Supervision: Unlicensed Staff policy, dated August 1, 2021, indicated the licensee had a registered nurse available for consultation to licensee staff 24 hours a day, 7 days a week.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 0 520 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for | 0 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 550 | Continued From page 13<br><br>Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances and the contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities (OOLTC). This had the potential to affect all the licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 10:10 a.m., during a facility tour, the common areas shared by residents, staff, and visitors lacked a | 0 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 550 | Continued From page 14<br><br>posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances and contact information for the OOLTC.<br><br>On February 23, 2026, at approximately 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged the required content was not posted in the common areas. LALD/CNS-A stated it was an oversight, and the licensee would post the grievance procedure with the required information.<br><br>The licensee's Grievance policy, dated August 1, 2021, indicated the licensee would post the grievance procedure in the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time | 0 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 580 | Continued From page 15<br>of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 10:55 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented.<br><br>The licensee's Quality Management Program policy, undated, indicated the licensee would have a continuous QMP in place and documentation would be provided upon request.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-C).<br><br>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 | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 17<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 10:45 a.m., during the entrance conference, LALD/CNS-A stated they were responsible for all orientation and training requirements for the licensee.<br><br>LALD/CNS-A<br>LALD/CNS-A was hired on March 15, 2015.<br><br>LALD/CNS-A's employee record included a signed one-page document titled Orientation Checklist, undated, that indicated the completed dates for LALD/CNS-A's orientation content were not entered.<br><br>LALD/CNS-A's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to:<br>-Overview of Assisted Living statutes;<br>-Review of provider's policies and procedures;<br>-Handling emergencies and using emergency services;<br>-Reporting maltreatment of vulnerable adults or minors;<br>-Assisted Living Bill of Rights;<br>-Handing of resident complaints, reporting of complaints, where to report;<br>-Consumer advocacy services;<br>-Review of types of Assisted Living services the employee will provide and provider's scope of | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 18<br><br>license; and<br>-Orientation to each specific resident and services provided.<br><br>On February 23, 2026, at approximately 3:00 p.m., LALD/CNS-A stated they completed the required orientation but did not document the dates of the completed orientation and it was an oversight.<br><br>RN-B<br>RN-B was hired on November 1, 2023.<br><br>RN-B's employee record lacked annual performance reviews for 2024 and 2025.<br><br>By the end of the survey, the licensee did not provide any documents that indicated RN-B received annual performance reviews for 2024 and 2025.<br><br>ULP-C<br>ULP-C was hired on October 1, 2021.<br><br>ULP-C's employee record included annual performance reviews for 2022 and 2023 but lacked documentation of a completed annual performance review for 2024 and 2025.<br><br>On February 23, 2026, at approximately 3:05 p.m., LALD/CNS-A stated the licensee forgot to complete an annual performance evaluation for ULP-C in 2024 and 2025 and was unsure why.<br><br>The licensee's Personnel Records policy, dated August 1, 2021, indicated the licensee would include records of orientation and annual training in the employee's files.<br><br>No further information was provided. | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 19<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a TB baseline screening for one of one employee (registered nurse (RN)-B).<br><br>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 | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 20<br><br>cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>The licensee completed a facility TB risk assessment on January 2, 2026, which indicated the licensee was a low risk for TB.<br><br>RN-B had a hire date of November 1, 2023.<br><br>On February 25, 2026, at 8:57 a.m., per phone interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor requested RN-B's employee file.<br><br>On February 26, 2026, at 11:23 a.m., per phone interview with LALD/CNS-A, the surveyor requested RN-B's employee file a second time.<br><br>On February 26, 2026, at 11:28 a.m., the licensee emailed the surveyor RN-B's employee file for review.<br><br>RN-B's employee record included a TB Exam Result document, dated May 27, 2025, indicated a chest x-ray was performed but lacked documentation of a completed TB history and symptom screen and TB testing at time of RN-B's hire.<br><br>On February 26, 2026, at 2:26 p.m., per phone interview with LALD/CNS-A, the surveyor asked if RN-B completed a TB history and screen and TB testing upon hire. LALD/CNS-A did not respond to the RN-B TB question and requested the surveyor send an email for this request. | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 21<br><br>On February 26, 2026, at 2:48 p.m., via email, the surveyor requested the licensee to email the surveyor RN-B's TB history and screen and TB testing documents by the end of business day today (4:00 p.m.). The licensee did not email the surveyor the requested RN-B's TB documents by the end of business day.<br><br>By the end of the survey, the licensee did not provide any documents that indicated the RN-B completed a TB history and screening and a TB testing upon hire.<br><br>The licensee's Tuberculosis Screening policy, undated, indicated all staff are required as a part of their employment to be screened and tested for TB.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the Centers for Disease Control and Prevention (CDC) guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 22 | 0 680 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.<br><br>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 | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 23<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a binder and stated the contents were the licensee's EPP.<br><br>The licensee's EPP, undated, lacked an individualized plan to include all the required content below:<br>-missing annual review;<br>-missing resident quarterly review;<br>-missing Hazard Vulnerability Analysis (HVA) assessment;<br>-EPP resident population<br>-process for EP collaboration;<br>-development of all policies/procedures (P/P) based on HVA assessment;<br>-arrangement of other facilities;<br>-roles under a waiver declared by secretary;<br>-communication plan; and<br>-EP training and testing program.<br><br>On February 23, 2026, at approximately 3:00 p.m., LALD/CNS-A acknowledged the licensee's EPP lacked the above listed required content. LALD/CNS-A stated the licensee was not aware of the HVA assessment and all the requirements of Appendix Z.<br><br>The licensee's Emergency Management policy, undated, indicated the licensee would have an | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 24<br><br>identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.<br><br>The licensee's Missing Resident policy, dated August 1, 2021, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 720 SS=F | 144G.43 Subd. 2 Access to records<br><br>The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized representative.<br><br>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 | 0 720 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 720 | Continued From page 25<br><br>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 9:00 a.m., during the entrance phone call with the licensee, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's resident records were in a locked office and only the LALD/CNS-A had the keys for the locked office. The surveyor informed LALD/CNS-A that the surveyor would need access to the resident records for the survey.<br><br>On February 23, 2026, at 9:05 a.m., the surveyor emailed the licensee the entrance email that indicated resident records must be available for review.<br><br>On February 23, 2026, at 10:50 a.m., during the entrance conference, the surveyor provided the LALD/CNS with a list of requested documents and records needed for R2.<br><br>On February 23, 2026, at 11:10 a.m., LALD/CNS-A stated the licensee's resident records were stored offsite at another facility under the licensee's umbrella. LALD/CNS-A also stated she would drive to the other facility to retrieve the records and return. LALD/CNS-A further stated the other facility was not far and it would not take long.<br><br>On February 23, 2026, at 11:15 a.m., LALD/CNS-A left the facility.<br><br>On February 23, 2026, at 1:20 p.m., LALD/CNS-A returned to the facility with the licensee's | 0 720 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 720 | Continued From page 26<br><br>tuberculosis (TB) risk assessment and a discharged summary for R1. LALD/CNS-A did not provide the requested documents and record for R2.<br><br>On February 23, 2026, at 1:25 p.m., LALD/CNS-A stated she forgot to bring R2's record and would call someone to bring R2's record.<br><br>On February 23, 2026, at approximately 2:00 p.m., an unidentified staff member of the licensee arrived with R2's resident record.<br><br>On February 23, 2026, at approximately 3:00 p.m., LALD/CNS-A stated the licensee was not aware of the requirement to have the resident records readily available for staff and surveyors. LALD/CNS-A also stated the licensee would move the resident records onsite at the facility where the residents resided.<br><br>The licensee's Clinical Records policy, dated August 1, 2021, indicated the licensee would maintain resident records in such a manner that allows for timely access.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 720 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced | 0 775 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 775 | Continued From page 27<br>by:<br>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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 775 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate | 0 780 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 780 | Continued From page 28<br><br>sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 780 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 780 | Continued From page 29<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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 | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 800 | Continued From page 30<br>failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 810 | Continued From page 31<br><br>include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 830 SS=F | 144G.45 Subd. 3 Local laws apply<br><br>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at 10:10 a.m., during a tour of the facility, the surveyor observed a designated smoking area outdoors next to the front porch with a metal cigarette disposal receptacle located in the vicinity. | 0 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 830 | Continued From page 33<br><br>On February 23, 2026, at approximately 11:00 a.m., the surveyor smelled cigarette smoke in R2's room and observed loose tobacco leaves, cigarette rolling paper, and a rolling tray device on top of a plastic tray that was placed on a two-drawer nightstand next to R2's bed. The surveyor also observed cigarette ashes and burn marks on the windowsill of the partially opened window next to R2's bed.<br><br>On February 23, 2026, at approximately 11:05 a.m., on the outside back portion of the facility where R2's bedroom window was located, the surveyor observed cigarette ash marks on the vinyl siding that streaked downward from the windowsill. The surveyor also observed multiple cigarette butts on the ground below R2's window that had been burned down to the filter of the cigarette.<br><br>On February 23, 2026, at approximately 11:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-C verified the cigarette supplies, ashes, and burn marks in R2's room.<br><br>On February 23, 2026, at approximately 11:15 a.m., ULP-C stated the licensee placed a no smoking sign on R2's room door and reminded R2 not to smoke indoors.<br><br>R2 was admitted to the licensee on March 10, 2023, with a diagnosis of Korsakoff syndrome (neurological disorder), and resided in room two on the upper level of the facility.<br><br>R2's signed Assisted Living Contract, dated March 10, 2023, indicated on page six, section 10 Fire Safety, that there was no smoking in the licensee's facility. | 0 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 830 | Continued From page 34<br><br>R2's record included a Smoking Safety Evaluation document, dated March 6, 2024, that indicated R2 frequently smoked inside the facility during the night and early hours of the morning.<br><br>R2's record included a Smoking Safety Assessment document, dated October 31, 2025, that indicated R2 smoked in bed sometimes.<br><br>On February 23, 2026, at approximately 3:00 p.m., LALD/CNS-A stated the licensee was aware that R2 had smoked indoors, and the licensee had redirected R2 to smoke outdoors in the designated smoking area, but the behavior persisted.<br><br>The licensee's Fire Safety policy, dated August 1, 2021, indicated the facility's environment would be maintained regarding health and safety of the residents.<br><br>The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier.<br><br>Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or | 0 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 830 | Continued From page 35<br><br>resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 830 | | |
| 0 910 SS=C | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2).<br><br>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 or represent a systemic failure that has affected | 0 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 0 910 | Continued From page 36<br>or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R2 was admitted on March 10, 2023.<br><br>On February 2, 2026, at approximately 2:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided R2's [licensee] Resident Contract for Assisted Living and stated the contract was used by the licensee for all residents who would live in the facility.<br><br>R2's Assisted Living Contract dated March 10, 2023, lacked inclusion with the licensee's Health Facility Identification (HFID) number.<br><br>On February 23, 2026, at approximately 2:40 p.m., LALD/CNS-A stated the licensee was not aware of the requirement to have the HFID number on the contract.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 910 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>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. | 0 970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 37<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided R2's Assisted Living Contract and stated the contract was used by the licensee for all residents who would live in the facility.<br><br>The licensee's Assisted Living Contract dated March 10, 2023, on page 12, included a section titled Insurance Liability and Release and read, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage ...".<br><br>The licensee's Assisted Living Contract dated March 10, 2023, on page 14, included a section titled Indemnification and read, "[licensee] shall not be liable for any damage or injury to the resident ...". | 0 970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 38<br><br>On February 23, 2026, at approximately 2:50 p.m., LALD/CNS-A acknowledged the licensee's assisted living contract included waivers of liability for health and safety or personal property of the resident. LALD/CNS-A also stated the liability waivers would need to be removed from the licensee's contracts.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01460 SS=F | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>(a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b).<br>(b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 39<br><br>supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensure requirements and regulations before providing assisted living services to residents for one of three employees (registered nurse (RN)-B).<br><br>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).<br><br>The findings include:<br><br>RN-B was hired on November 1, 2023, to provide direct care to residents and supervise employees.<br><br>On February 25, 2026, at 8:57 a.m., per phone interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor requested RN-B's employee file. | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 40<br><br>On February 26, 2026, at 11:23 a.m., per phone interview with LALD/CNS-A, the surveyor requested RN-B's employee file a second time.<br><br>On February 26, 2026, at 11:28 a.m., the licensee emailed the surveyor RN-B's employee file for review.<br><br>RN-B's employee record lacked documentation of an orientation upon hire.<br><br>On February 26, 2026, at 2:26 p.m., per phone interview with LALD/CNS-A, the surveyor asked if RN-B completed an orientation upon hire. LALD/CNS-A did not respond to the RN-B orientation question and requested the surveyor send an email for this request.<br><br>On February 26, 2026, at 2:48 p.m., via email, the surveyor requested the licensee to email the surveyor RN-B's orientations documents by the end of business day today (4:00 p.m.). The licensee did not email the surveyor the requested RN-B's orientation documents by the end of business day.<br><br>By the end of the survey, the licensee did not provide any documents that indicated the RN-B completed an orientation upon hire.<br><br>The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated the licensee would provide orientation to employees upon hire and before providing service to residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 41<br>(21) days | 01460 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br>(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:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 42<br><br>annual training may also contain training on providing services to residents with hearing loss. 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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-C).<br><br>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 | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 43<br>a large portion or all of the residents).<br><br>The findings include:<br><br>LALD/CNS-A<br>LALD/CNS-A had a hire date of March 15, 2015.<br><br>LALD/CNS-A's training records for 2022, 2023, 2024, and 2025 lacked evidence of the eight hours annual training requirement to include review of the provider's policies and procedures.<br><br>RN-B<br>RN-B had a hire date of November 1, 2023.<br><br>RN-B's record included annual training for 2025 but lacked annual training for 2024 to include the following:<br>-Reporting maltreatment of vulnerable adults or minors;<br>-Assisted Living Bill of Rights;<br>-Infection control techniques;<br>-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;<br>-Review of provider's policies and procedures; and<br>-Principles of person-centered planning/service delivery.<br><br>By the end of the survey, the licensee did not provide any documents that indicated RN-B completed annual training for 2024.<br><br>ULP-C<br>ULP-C had a hire date of October 1, 2021.<br><br>ULP-C's training records for 2022, 2023, 2024, | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 44<br><br>and 2025 lacked evidence of the eight hours annual training requirement to include review of provider's policies and procedures.<br><br>On February 23, 2025, at 2:00 p.m., LALD/CNS-A stated the licensee forgot to include review of provider's policies and procedures to the required annual training and would ensure all the required annual training for employees would be completed.<br><br>The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated the licensee would include review of the provider's policies and procedures in the employee's annual training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01530 SS=F | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 45<br><br>employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training and two hours of mental illness and de-escalation training within the first 120 working hours of employment for supervisors of direct care staff as required for one of one registered nurse (RN)-B.<br><br>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 | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 46<br><br>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).<br><br>The findings include:<br><br>On February 23, 2026, at approximately 10:35 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated RN-B worked at the facility as a backup nurse as needed.<br><br>On February 23, 2026, at 10:09 a.m., per phone interview, RN-B stated she worked for the licensee two (2) to three (3) days a month.<br><br>RN-B was hired on November 1, 2023, to provide direct care to residents and supervise employees.<br><br>On February 25, 2026, at 8:57 a.m., per phone interview with LALD/CNS-A, the surveyor requested RN-B's employee file.<br><br>On February 26, 2026, at 11:23 a.m., per phone interview with LALD/CNS-A, the surveyor requested RN-B's employee file a second time.<br><br>On February 26, 2026, at 11:28 a.m., the licensee emailed the surveyor RN-B's employee file for review.<br><br>RN-B's employee record lacked documentation of eight hours of initial dementia care training and two hours of mental illness and de-escalation training within the first 120 working hours of employment. | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 47<br><br>On February 26, 2026, at 2:26 p.m., per phone interview with LALD/CNS-A, the surveyor asked if RN-B completed dementia and mental illness training upon hire. LALD/CNS-A did not respond to the RN-B dementia and mental illness training question and requested the surveyor send an email for this request.<br><br>On February 26, 2026, at 2:48 p.m., via email, the surveyor requested the licensee to email the surveyor RN-B's dementia and mental illness training documents by the end of business day today (4:00 p.m.). The licensee did not email the surveyor the requested RN-B's dementia and mental illness documents by the end of business day.<br><br>By the end of the survey, the licensee did not provide any documents that indicated RN-B completed dementia care and mental illness training within the first 120 working hours of employment.<br><br>The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated the licensee would provide all staff a thorough orientation and education program.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>(a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 03090 | Continued From page 48<br><br>record persons and activities."<br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility.<br><br>This practice resulted in a level one violation (a violation that has not 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On February 23, 2026, at 10:00 a.m., the surveyor observed a doorbell with a camera system installed at the main entrance accessible by visitors to the facility that lacked the required notice for electronic monitoring.<br><br>On February 23, 2026, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee thought the required verbatim notice was posted at the entrance accessible by visitors and was unsure why it was not posted. LALD/CNS-A also stated the required electronic monitoring posting would need to be placed at the entrance. | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34949 | A. BUILDING: _____ B. WING _____ | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOBBY'S HOUSE | 9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444 |

| (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 |
|---|---|---|---|---|
| 03090 | Continued From page 49<br><br>The licensee's Electronic Monitoring policy, dated August 1, 2021, indicated the licensee would comply with the Minnesota Electronic monitoring law.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 03090 | | |

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

Bobby's House
9200 James Avenue North
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 34949

Risk:
License:
Expires on:
CFPM: Thomasia Naya
CFPM #: CFPM-58283; Exp: 2/8/2028

## Inspection Info

Report Number: F1047261062
Inspection Type: Full - Single
Date: 2/24/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

**New Order: 2-100 Supervision**
2-102.11D,E,F,G,H,I *Priority Level: Priority 2 CFP#: 1*
*MN Rule 4626.0030DEFGHI* The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.
COMMENT: Person in charge did not know the final cooking temperatures of foods. Information on final cooking temps provided.

Person in charge unable to locate dishwasher temperature strips and cooking gloves initially. Items were located but facility should implement an organizational system so that all staff can locate the necessary tools for food safety.

*Comply By: 2/24/2026 Originally Issued On: 2/24/2026*

**New Order: 2-100 Supervision**
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
*MN Rule 4626.0033D* Post the certified food protection manager certificate.
COMMENT: Repeat order- first issued 3/4/2024.

CFPM certificate not posted. Keep certificate posted at the facility

*Comply By: 2/24/2026 Originally Issued On: 2/24/2026*

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
*MN Rule 4626.0040C* The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: Employee illness log not available on site. Example log provided with report.

*Comply By: 2/24/2026 Originally Issued On: 2/24/2026*

! **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: Raw eggs stored above ready to eat grapes. Discussed appropriate storage locations

*Comply By: 2/24/2026 Originally Issued On: 2/24/2026*

**New Order: 4-500 Equipment Maintenance and Operation**
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
*MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: Drawer in kitchen is broken and no longer functional. Repair drawer.

*Comply By: 3/3/2026 Originally Issued On: 2/24/2026*

## Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator C. Samrock.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

**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 F1047261062 from 2/24/2026**

Natalie Campbell
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@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

Bobby's House
Brooklyn Park
County/Group: Hennepin County

## Inspection Info

Report Number: F1047261062
Inspection Type: Full
Date: 2/24/2026
Time: 10:00 am

**Food Temperature: Product/Item/Unit:** Bologna**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 39 Degrees F.
Comment:
*Violation Issued?: No*

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL34949016 | **Date:** 2/24/2026 |
| **Facility Name:** Bobbys House | |
| **Facility Address:** 9200 James Ave N Brooklyn Park, Minnesota 55444 | |

☒ **TAG IDENTIFICATION: 0775**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

   *Comments: It was observed that cigarette butts were discarded on the ground with no visible suitable non-combustible ashtrays or match receivers provided.*

3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   *Comments: During the survey, burn marks were observed on the windowsill in Resident Room 2. Immediately outside the window on the exterior of the building, discarded cigarette butts and ash were observed on the ground below the window*

4. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   *Comments: During survey tour, it was observed that there were smoke alarm brackets with no smoke alarm in the upstairs hallway adjacent to resident room 2 and at the base of the stairs in the lower level. Both locations had visible building wiring indicating that the previous smoke alarms were hard-wired. Smoke alarms of the same type of power supply were not provided to replace the removed devices*

☒ **TAG IDENTIFICATION: 0780**

**SCOPE/ SEVERITY:** Level 2; 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: During survey tour, it was noted the smoke alarm in the basement hallway adjacent to the Lower-level bedroom was removed. Only a smoke alarm bracket was in place.*

2. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   *Comments: During test of smoke alarms on February 24th, 2026, at 10:45 AM when initial test was conducted, the facility failed to have all working smoke alarms interconnected.*

---

☒ **TAG IDENTIFICATION: 0800**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   *Comments:*

   - *During the survey, fire damage was observed on the exterior sunroom and attached deck. Staff reported the damage resulted from a fire that occurred on October 11, 2025. The damaged areas remained visible at the time of the survey*
   - *Water damage to the ceiling in the lower-level hallway.*
   - *During the survey, excessive and unorganized combustible storage was observed in the attached garage connected to the facility. Boxes and miscellaneous stored materials were observed throughout the garage area. The accumulation of combustible materials in this area increased the potential fire load and presented a potential fire and safety hazard to the building.*

---

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   *Comments: The facility's fire safety and evacuation plan (FSEP) was an unedited third party written policy. The plan has not been updated to include specific employee actions to be taken in the event of fire or similar emergency at this facility.*

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   *Comments: The Licensee FSEP did not include specific procedures for residents in the case of a fire or emergency evacuation.*

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   *Comments: LALD-A was unable to provide us with any staff training records on the fire and evacuation plans at time of survey.*