



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2026

Licensee
The Kenwood
825 Summit Avenue
Minneapolis, MN 55403

RE: Project Number(s) SL30594016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 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.

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

pursuant to this survey:

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
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. 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.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER THE KENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 825 SUMMIT AVENUE MINNEAPOLIS, MN 55403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30594016-0 On September 14, 2026, through September 17, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 86 residents; 14 receiving services under the Assisted Living Facility license. An immediate order for correction was identified on September 15, 2026, issued for SL30594016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on September 16, 2026.	0 480			

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0 480	Continued From page 3	0 480			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post their emergency preparedness plan (EPP) prominently for staff, residents, and visitors to view.	0 680			

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0 680	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2026, at 10:38 a.m., during the facility tour, the surveyor observed the licensee did not have an EPP visible or signage directing where to find their EPP. On September 16, 2026, at 7:05 a.m., the surveyor asked front desk receptionist (FD)-L if they knew the location of the EPP. FD-L stated they did not know and the surveyor should check with licensed assisted living director (LALD)-D. The surveyor requested the EPP from LALD-D while in LALD-D's office. LALD-D had the EPP in their office and provided it to the surveyor. LALD-D stated they stored the EPP in their office and they did not have posted signage directing people where to find the EPP. The licensee's 9.01 Emergency Preparedness Plan policy dated March 1, 2026, indicated, "It is the intent that [licensee] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance."	0 680			

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0 680	Continued From page 5 Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730			

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0 730	Continued From page 6 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for three of three residents (R2, R3, R4). 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	0 730			

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0 730	Continued From page 7 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on February 19, 2024. R2's Service Plan dated January 1, 2026, and signed January 21, 2026, indicated R2 received services for case management (registered nurse, licensed practical nurse, licensed social worker services, and oversight of cares), medication management, assist with AM cares (assist with activities of daily living and hygiene), and emergency pendant (lifeline service response system 24 hours). R2's Task Administration Record (service plan documentation record) for September 2026, indicated the licensee lacked documentation for the following services and dates: -med pass; September 1 at 8:00 a.m.; -med set up; September 11; and -reminder; September 6 at 12:00 p.m. On September 15, 2026, at 9:11 a.m., the surveyor observed ULP-C administer medications for R2. R3 R3 was admitted to the licensee on August 8, 2024. R3's Service Plan dated January 1, 2026, and signed January 4, 2026, indicated R3 received services for case management, and emergency	0 730			

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0 730	Continued From page 8 pendant. R3's Service Summary Report dated September 16, 2026, indicated R3 received services for daily weight, medication pass, medi-set, monthly vitals, pick up med set, return medi-set, weight monitoring and medication pass. The Service Summary Report did not match the signed service plan from January 1, 2026. R3's Task Administration Record for August and September 2026 indicated the licensee lacked documentation for the following services and dates; -medi-set; August 8; -weight monitoring; August 1, 2,5, 29, 30; September 5-8; and -tezspire injection; August 28. On September 15, 2026, at 9:21 a.m., the surveyor observed ULP-C administer medications for R3 and obtain R3's weight. R4 R4 was admitted to the licensee on August 19, 2025. R4's Service Plan dated and signed December 30, 2025, indicated R4 received services for "Gold Package" which can include: "Incontinence care--4 bathroom assists daily, Linen change weekly. AM and PM cares daily (up to 15 min each visit). Med management up to 3 times day (Medication set up by RN/LPN). Bathing assist 2 x week. 2 nightly comfort checks. Escorts to meals/activities (up to 3 x a day). Emergency pendant. 2 loads of laundry a week. Three meals a day. Case Management, Lifeline response system."	0 730			

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0 730	Continued From page 9 R4's Task Administration Record for August and September 2026 indicated the licensee lacked documentation for the following services and dates; -90-day supervisory visit; August 8; -comfort check/toileting; September 5 at 6:30 a.m.; -return medi-set; August 23; and -supplies; August 1, and September 1; On September 15, 2026, at 8:39 a.m., the surveyor observed ULP-B administer medications for R4. On September 16, 2026, at 10:49 a.m., clinical nurse supervisor (CNS)-A reviewed R2, R3 and R4's Task Administration Record (TAR) for September and August 2026 and stated the services a resident received should be documented on the TAR. CNS-A stated the TARs were missing documentation, and their expectation was the records be complete. CNS-A stated audits are done about twice a month to ensure there is no missing documentation of services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

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0 775	Continued From page 10 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780			

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(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 11 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780			

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0 780	Continued From page 12 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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. (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. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice	0 810			

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0 810	Continued From page 13 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=H	144G.60 Subdivision 1 Background studies required	01290			

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01290	Continued From page 14 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they had a background study (BGS) on NETStudy 2.0 (web-based system used to submit BGS requests to the Department of Human Services (DHS)) affiliated with the assisted living licensee's health facility identification number (HFID) for three of ten employees (dishwasher (DW)-F, server (S)-G, business office manager (BOM)-H.) This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01290			

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01290	Continued From page 15 The findings include: The licensee's HFID was 30594. The licensee also had access in NETStudy2.0 to their former HFID 20341. DW-F DW-F was hired on April 28, 2015, to work in the facility kitchen. S-G S-G was hired on May 7, 2018, to serve residents their meals. BOM-H BOM-H was hired on January 28, 2013, to perform business duties for the licensee. The licensee's undated NETStudy 2.0 report for HFID 30594, printed on September 15, 2026, provided to the surveyor by licensed assisted living director (LALD)-D did not include DW-F, S-G, or BOM-H. The licensee's undated NETStudy 2.0 report for HFID 20341, printed on September 15, 2026, provided to the surveyor by resident service director (RSD)-J did not include DW-F, S-G, or BOM-H. The licensee's current Employee List dated September 8, 2026, indicated: -DW-F was hired on April 28, 2015; -S-G was hired on May 7, 2018; and -BOM-H was hired on January 28, 2013. On September 15, 2026, at 8:14 a.m., RSD-J provided clearance letters for DW-F, S-G, and BOM-H which were all completed under HFID 20341.	01290			

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01290	Continued From page 16 On September 15, 2026, at 8:15 a.m., RSD-J stated they were the one who completed BGS for the licensee. RSD-J stated they did have access to both HFID 20341 and 30594 on NETStudy 2.0 and were able to demonstrate to the surveyor on their computer. On September 15, 2026, at 8:29 a.m., the surveyor explained to RSD-J the NETStudy2.0 roster for HFID 20341 also did not include DW-F, S-G, and BOM-H; the surveyor requested they search for each staff individually in NETStudy 2.0 to see if they were able to locate an affiliation history. On September 15, 2026, at 8:56 a.m., RSD-J stated they were unable to find any information about DW-F, S-G, and BOM-H in NETStudy 2.0 of any kind. The surveyor encouraged RSD-J to contact NETStudy personnel if they wanted further answers. On September 15, 2026, at 10:04 a.m., RSD-J stated they talked to NETStudy and they were no longer able to provide information from NETStudy 1.0 as they had fully transitioned to NETStudy 2.0; they were told they needed to run new BGS for DW-F, S-G, and BOM-H. On September 15, 2026, at 10:36 a.m., LALD-D stated DW-F, S-G, and BOM-H worked in the facility and reported to supervisors but were not under direct supervision while working their scheduled shifts. The licensee's Staffing the Assisted Living policy, undated, indicated: "Background studies required. Employees, contractors, and regularly scheduled	01290			

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01290	Continued From page 17 volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. The facility may require self-disclosure of criminal conviction information. Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620			

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01620	Continued From page 18 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment at least every 90 days for one of three residents (R2). In addition, the facility failed to ensure an accurate comprehensive assessment for one of three residents (R4). This practice resulted in a level two violation (a	01620			

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01620	Continued From page 19 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Timely Assessments R2 was admitted to the licensee on February 19, 2024. R2's Service Plan dated January 1, 2026, and signed January 21, 2026, indicated R2 received services for case management (registered nurse, licensed practical nurse, licensed social worker services and oversight of cares), medication management, assist with AM cares (assist with activities of daily living and hygiene), and emergency pendant (lifeline service response system 24 hours). R2's ECP (charting software) assessment listed the following assessments: -March 3, 2025, 90-day assessment; -June 19, 2025, 90-day assessment (108 days since last comprehensive assessment); -September 17, 2025, 90-day assessment (90 days since last comprehensive assessment); -January 28, 2025, 90-day assessment (133 days since last comprehensive assessment); -April 29, 2026, 90-day assessment (91 days since last comprehensive assessment); and -May 27, 2026, 90-day assessment (28 days since last comprehensive assessment). ECP did not list any additional comprehensive assessments after May 27, 2026.	01620			

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01620	Continued From page 20 A review of R2's progress notes, dated August 1, 2026, through September 16, 2026, indicated the following: -progress note dated August 26, 2026, indicated R2 refused nurse visit for 90-day assessment and would let nurse know when she was ready to complete the assessment. R2's record contained no additional notes regarding refusal or attempts to complete the comprehensive assessment. On September 15, 2026, at 9:11 a.m., the surveyor observed ULP-C administer medications for R2. On September 16, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated R2's last comprehensive assessment was completed on May 27, 2026. CNS-A stated they attempted to complete an assessment on August 26, 2026, and R2 refused the assessment. CNS-A stated she had tried one time since then but did not document the attempt. CNS-A stated R2 had behaviors and would refuse assessments. CNS-A stated the requirement was to complete a comprehensive assessment at least every 90 days in addition to a pre-admission assessment, admission assessment, 14-day assessment and change of condition assessment which they were responsible to complete. Inaccurate Assessment R4 was admitted to the licensee on August 19, 2025. R4's Service Plan dated and signed December 30, 2025, indicated R4 received services for "Gold Package" which can include: "Incontinence care--4 bathroom assists daily, Linen change	01620			

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01620	Continued From page 21 weekly. AM and PM cares daily (up to 15 min each visit). Med management up to 3 times day (Medication set up by RN/LPN). Bathing assist 2 x week. 2 nightly comfort checks. Escorts to meals/activities (up to 3 x a day). Emergency pendant. 2 loads of laundry a week. Three meals a day. Case Management, Lifeline response system." R4's Medication Administration Assessment dated August 12, 2026, indicated the following; Areas marked as R2 needing assistance: -can state name of medication (noted resident is on medication management); -knows what each med is for; -can read bottle for name and dosage; -knows when to take each medication; -remember to take each medication on time; and -able to open containers; Problem area identified: -taking medication inappropriately ("resident misses doses while at her independently living. Kenwood is managing resident's medications"); Services needed based on assessment: -assistance with self-administration of medication; and -administration of medication. Prevention of diversion of medication implemented: -medication listed in resident's cabinet in apartment; and -nurse has medication locked in their office. The assessment did not indicate R2 could safely self-administer medications. R4's comprehensive RN assessment after hospitalization dated August 12, 2026, indicated R4 "needs help taking medication-med administration." Furthermore, the assessment indicated R4 "needs full medication set up by	01620			

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01620	Continued From page 22 nurse" and "needs medication ordered." On September 15, 2026, at 8:39 a.m., the surveyor observed ULP-B administer medications for R4. On September 15, 2026, at 11:26 a.m., R4 stated they take their own supplements. R4 stated the facility recently transitioned her to be able to take her own supplements but could not give a date when the transition occurred. R4 stated the facility managed all other medications. On September 15, 2026, at 11:39 a.m., CNS-A stated R4 had an order to self-administer supplements dated July 28, 2026, which was provided. CNS-A stated R4's assessments completed by the facility did not reflect R2 would be able to self-administer mediations and documented as it would not be appropriate. CNS-A stated there was not a good place in the assessment to document that R4 was able to self-administer supplements and facility to manage other medications. CNS-A stated the facility policy was an order signed by the provider was needed for all medications including over the counter medications. The licensee's Medication Prescriptions and Refills policy, undated, indicated "a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident." No other medication management policies were provided.	01620			

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01620	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to revise and obtain a resident or resident representative's signature documenting a change of services to be provided for one of three residents (R3).	01640			

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01640	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on August 8, 2024. R3's Service Plan dated January 1, 2026, and signed January 4, 2026, indicated R3 received services for case management, and emergency pendant. R3's Service Summary Report dated September 16, 2026, indicated R3 received services for daily weight, medication pass, medi-set, monthly vitals, pick up med set, return mediset, weight monitoring and medication pass. The Service Summary Report did not match the signed service plan from January 1, 2026. On September 15, 2026, at 9:21 a.m., the surveyor observed ULP-C administer medications for R3 and obtain R3's weight. On September 16, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated the service plans for R3 had not been updated and signed when R3 started medication management. CNS-A stated the service plan should have been updated and signed when R3 started on an elderly waiver. CNS-A stated R3 started on mediation management on March 17, 2026.	01640			

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(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
01640	Continued From page 25 CNS-A stated they were responsible for ensuring service plans are accurate and signed and did not give a reason for R3's service plan not being updated and signed. CNS-A stated when a resident has "case management" on their service plan, they are considered a resident needing assisted living services but described it as "a middle ground" as there were no scheduled tasks. The licensee's document titled Section 2 - Assisted Living Contracts, undated, indicated "the resident must agree in writing to any additions or amendments to the contract. If agreed to, a new contract of addendum to the existing contract must be executed and signed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
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01760	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff accurately documented medication administration for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on February 19, 2024. R2's Service Plan dated January 1, 2026, and signed January 21, 2026, indicated R2 received services for case management (registered nurse, licensed practical nurse, licensed social worker services and oversight of cares), medication management, assist with AM cares (assist with activities of daily living and hygiene), and emergency pendant (lifeline service response system 24 hours). R2's August 2026, Med Admin Summary (medication administration record (MAR)) lacked documentation of medication administration for the following medications, dates, and times: -med pass; August 1, 31 at 8:00 a.m., and August 17 at 8:00 p.m.	01760			

Minnesota Department of Health

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01760	Continued From page 27 R2's September 2026 MAR, printed September 15, 2026, lacked documentation of medication administration for the following medications, dates and times: -vitamin D3 25 micrograms (mcg), take one capsule by mouth two times daily; September 5-10 at 8:00 a.m., and August 5-9 at 8:00 p.m.; -daily-vite tab 400 mcg, take one tablet by mouth once daily; September 5-10 at 8:00 a.m.; -fish oil 1000 milligrams (mg), take two capsules by mouth once daily in the morning; September 5-9 at 8:00 p.m.; -oxybutynin chloride 10 mg, take one tablet by mouth once daily at bedtime; September 5-9 at 8:00 p.m.; -rosuvastatin calcium 10 mg, take one tablet by mouth at bedtime; September 5-9 at 8:00 p.m.; -venlafaxine hydrochloride 150 mg, take one capsule by mouth once daily with meals in the morning; September 5-10 at 8:00 a.m.; -med pass, administer medication from med set. Verify you are taking medications out of the right day/time slot; September 1 at 8:00 a.m.; -aspirin EC 81 mg, take one tablet by mouth two times day; September 5-10 at 8:00 a.m., and August 5-9 at 8:00 p.m.; and -donepezil HCL 10 mg, give one tablet by mouth daily at bedtime; September 5-10 at 11:30 p.m. On September 15, 2026, at 9:11 a.m., the surveyor observed ULP-C administer the following medications to R2: -aspirin EC 81 mg, take one tablet by mouth two times day; -daily-vite tab 400 mcg, take one tablet by mouth once daily; -venlafaxine hydrochloride 150 mg, take one capsule by mouth once daily with meals in the morning; and	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
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01760	Continued From page 28 -vitamin D3 25 mcg, take one capsule by mouth two times daily. R3 R3 was admitted to the licensee on August 8, 2024. R3's Service Plan dated January 1, 2026, and signed January 4, 2026, indicated R3 received services for case management and emergency pendant. R3's Service Summary Report dated September 16, 2026, indicated R3 received services for daily weight, medication pass, medi-set, monthly vitals, pick up med set, return medi-set, weight monitoring and medication pass. The Service Summary Report did not match the signed service plan from January 1, 2026. R3's August 2026 MAR lacked documentation of medication administration for the following medications, dates, and times: -fluticasone propionate; one spray each nostril daily for allergies; August 1-7, 28-31; -tobramycin 0.3%-dexamethasone 0.1% eye drops; August 1-7, 28-31; -budesonide-glycopyrrolate-formoterol 160-9-4.8, inhale two puffs twice daily; August 2 and 11:30 a.m.; -tezepelumab-ekto (tezspire) 210mg/1.91ml, inject 1.91 ml (210 mg) subcutaneously every four weeks; August 28; -lidocaine patch 4%, apply two patches to skin daily at bedtime for 30 days, then two patches at bedtime as needed; August 28, 29 at 10:00 p.m.; -polyethylene 3350, take 17 grams (gm) by mouth daily in four to eight ounces of beverage; August 28-31 at 11:30 p.m.; and -thiamine 100 mg, take one tablet daily; August	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
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01760	Continued From page 29 28-31 at 11:30 p.m. R3's September 2026 MAR, printed September 15, 2026, lacked documentation of medication administration for the following medications, dates and times: -fluticasone propionate; one spray each nostril daily for allergies; September 1-14 at 11:30 p.m.; -tobramycin 0.3%-dexamethasone 0.1% eye drops; September 1-14 at 11:30 p.m.; -budesonide-glycopyrrolate-formoterol 160-9-4.8, inhale two puffs twice daily; September 5 at 11:30 a.m., and September 14 at 8:00 p.m.; -lidocaine patch 4%, apply two patches to skin daily at bedtime for 30 days, then two patches at bedtime as needed; September 11 at 8:00 p.m.; and -polyethylene 3350, take 17 gm by mouth daily in four to eight ounces of beverage; September 1-14 at 11:30 p.m. On September 15, 2026, at 9:21 a.m., the surveyor observed ULP-C administer the following medication to R3 and obtain R3's weight: - hydromorphone 2mg, take 1 mg (1/2 tab) 30 minutes prior to wound care, can take an additional 1mg (1/2 tab) every 12 hours PRN (as needed) for Pain. ULP-C updated R3 regarding R3's inhaler (budesonide-glycopyrrolate-formoterol 160-9-4.8) had not yet arrived from the pharmacy. On September 15, 2026, at 9:30 a.m., ULP-C stated they do not administer all R3's medications as the nurse sets them up in a medi-set and R3 takes them independently. ULP-C stated they do remind R3 to take them, and they administer R3's inhaler and obtain a daily weight.	01760			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER THE KENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 825 SUMMIT AVENUE MINNEAPOLIS, MN 55403		
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01760	Continued From page 30 R4 R4 was admitted to the licensee on August 19, 2025. R4's Service Plan dated and signed December 30, 2025, indicated R4 received services for "Gold Package" which can include: "Incontinence care--4 bathroom assists daily, Linen change weekly. AM and PM cares daily (up to 15 min each visit). Med management up to 3 times day (Medication set up by RN/LPN). Bathing assist 2 x week. 2 nightly comfort checks. Escorts to meals/activities (up to 3 x a day). Emergency pendant. 2 loads of laundry a week. Three meals a day. Case Management, Lifeline response system." R4's August 2026, MAR lacked documentation of medication administration for the following medications, dates, and times: -Eliquis 5 mg, take 5 mg by mouth twice a day; August 27 at 7:30 p.m.; -mediset, pass medications set up by Kenwood nursing; August 14, 17, 24, 27-30 at 7:45 a.m., and August 28, 30 at 7:30 p.m.; -Calmoseptine, apply to buttocks twice daily for preventive skin integrity management; August 5, 14, 17, 24 at 7:45 a.m., and August 27 at 7:30 p.m.; and -lidocaine 4%, apply to lower back daily in AM and remove after 12 hours in PM; August 14-15, 17 at 8:00 a.m. R4's September 2026 MAR, printed September 15, 2026, lacked documentation of medication administration for the following medications, dates, and times: -Eliquis 5 mg, take 5 mg by mouth twice a day; September 12, 14 at 7:30 p.m.; and -Calmoseptine, apply to buttocks twice daily for	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER THE KENWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 825 SUMMIT AVENUE MINNEAPOLIS, MN 55403			
(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
01760	Continued From page 31 preventive skin integrity management; September 4, 6 at 7:45 a.m., and September 10, 14 at 7:30 p.m. On September 15, 2026, at 8:39 a.m., the surveyor observed ULP-B administer the following medications for R4: - Eliquis 5 mg, take 5 mg by mouth twice a day. R4 declined calmoseptine cream. On September 16, 2026, at 10:48 a.m., clinical nurse supervisor (CNS)-A stated R2, R3, and R4's MARs were missing documentation. CNS-A stated their expectation was that staff administer medications as ordered and document accordingly. CNS-A stated staff were trained to document all refusals. CNS-A stated the facility recently changed over from nursing setting up all medications in medi-sets for residents to ULP's administering from each medication card. CNS-A stated some of the staff were not documenting accurately as they would sign the MAR that they administered medication from the medi-set despite administering each medication from a medication card. CNS-A did not give the specific date when the transfer took place. CNS-A stated nursing completed audits twice a month to ensure accurate and complete documentation. A facility policy titled Administration of Medication, Treatment, and Therapy by Unlicensed Personnel, reviewed January 9, 2026, indicated: "Documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our agency's procedures for documenting the MAR." No further information was provided.	01760			

Minnesota Department of Health

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01760	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01760			



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

Page: 1

Establishment Info

THE KENWOOD
825 SUMMIT AVENUE
Minneapolis, MN 55403
Hennepin County
Parcel:

Phone:

License Info

License: HFID 30594

Risk:
License:
Expires on:
CFPM: Lenesett Green
CFPM #: CFPM-23288; Exp:
11/2/2027

Inspection Info

Report Number: F1039261253
Inspection Type: Full - Single
Date: 9/15/2026 Time: 10:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision

2-102.11ABCQ *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.

COMMENT: PIC NOT AWARE OF ILLNESS LOGGING REQUIREMENT. LOGGING REQUIREMENT DESCRIBED TO PIC; ILLNESS LOG SHEET SENT WITH THIS REPORT.

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

New Order: 4-400 Equipment Location and Installation

4-402.11A *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

COMMENT: CAULK SEAL IS IN BAD REPAIR ON JOINT BETWEEN PREP SINK AND WALL. REMOVE OLD CAULKING AND RESEAL SINK TO WALL.

Comply By: 11/2/2026 Originally Issued On: 9/15/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: VINYL COVING STRIP AT FLOOR/WALL JUNCTION IN DRY STORES ROOM IS MISSING OR IN BAD REPAIR. REINSTALL A COVING STRIP AT FLOOR/WALL JUNCTION TO PREVENT MICE FROM ENTERING AT ANY GAP AT JUNCTION.

Comply By: 10/6/2026 Originally Issued On: 9/15/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD *Priority Level: Priority 3 CFP#: 38*

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

COMMENT: PERSONS-IN-CHARGE AND STAFF STATE THEY OBSERVE MOUSE ACTIVITY IN KITCHEN AND DRY STORES. ESTABLISHMENT DEPLOYS PLUNKETT'S AS PEST SERVICE WHO WILL WORK TO MORE AGGRESSIVELY MANAGE MICE. SEE PHYSICAL FACILITIES ORDER REGARDING EXCLUDING MICE FROM DRY STORES ROOM.

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluators Nancy Kimmes and Joey Keen.

BURGER - HOT HOLD IN STEAM WARMER - 169 DEGREES F
CHEESE/PACKAGED - COLD HOLD, WALK-IN COOLER - 38 DEGREES F
BUTTER/PACKAGED - COLD HOLD, WALK-IN COOLER - 38 DEGREES F
CUT MELON - COLD HOLD, PREP COOLER INSERT - 38 DEGREES F
CUT MELON - COLD HOLD, PREP COOLER INSERT - 39 DEGREES F
MILK - COLD HOLD, DAIRY COOLER - 41 DEGREES F
MILK - COLD HOLD, DINING ROOM BEVERAGE COOLER - 41 DEGREES F
FREEZER - FROZEN

Discussed the following topics with persons-in-charge: cleaning and sanitizing, cooling hot TCS foods, date marking, preventing cross-contamination, serving a highly susceptible population, hand hygiene, all orders on this report.

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 F1039261253 from 9/15/2026



(Lenesett) Renee Green
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

THE KENWOOD
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039261253
Inspection Type: Full
Date: 9/15/2026
Time: 10:15 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Equal To 100 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: 3-Comp Sink Equal To 400 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Equal To 300 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30594016-0	Date: September 17, 2026
Facility Name: THE KENWOOD	
Facility Address: 825 SUMMIT AVE, Minneapolis, MN, 55403	

☒ 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. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: In the underground parking garage, there was an extension cord running along the ceiling to the opposite end which provided continuous power to a flood light.

3. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: Fire alarm inspection and testing documents were dated August 26, 2025.

4. Water-based automatic sprinkler systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: Sprinkler system inspection and testing documentation was dated August 26, 2025.

5. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

Project Number: SL30594016-0

Facility Name: THE KENWOOD

Page | 1

Date: September 17, 2026

Comments: In the sprinkler control room, the fire pump had an error message displayed.

6. 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: In multiple rooms surveyed, the smoke alarms were over ten years old.

7. Interior vertical shafts, including stairways, elevator hoist ways, and service and utility shafts that connect two of more stories of a building, shall be enclosed or protected. When openings are required to be protected, opening protectives shall be maintained self-closing. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4, 1103.4.1]

Comments: In the East end stairwell going from the roof down 15 stories, there were unprotected penetrations for the sprinkler piping on each level landing.

8. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: In all resident units surveyed, the automatic door closers had been removed.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: In multiple surveyed residents' bedrooms there was not a smoke alarm present.

2. Smoke alarms 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: In surveyed rooms with a hard-wired smoke alarm in the living room and battery alarm in the bedroom, the alarms were not interconnected.

☒ **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 (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms and facility layout. Exit plan diagrams must be correctly labeled and accurate to the layout of the facility to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain an FSEP that includes 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. [Minn. Stat. 144G.45 subd.2]

Comments: The facility used an electronic care plan website for standard resident evacuation procedures. The FSEP doesn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

Comments: The licensed assisted living director (LALD)-D, failed to provide any record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

5. 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 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

6. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D lacked documentation showing evacuation drills occurred twice per year, per shift, with at least one evacuation drill every other month. No other information or documentation was provided.