



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 19, 2026

Licensee
Kekeli Care Center LLC
18315 82nd Place North
Maple Grove, MN 55311

RE: Project Number(s) SL39446016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39446016-0 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; both residents were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (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 information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311			
(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 4 safety but had the potential to have harmed a resident's 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 of the residents). The findings include: CNS-B CNS-B was hired December 21, 2023, and provided supervision to direct care staff and direct care for residents of the facility. CNS-B's employee record lacked documentation of annual performance reviews that would have identified areas of improvement needed and training needs. ULP-D ULP-D was hired on January 29, 2024, and provided direct care for the residents of the facility. ULP-D's employee record lacked documentation of an annual performance review that would have identified areas of improvement needed and training needs. On January 21, 2026, at 2:52 p.m., owner (O)-A stated licensee lacked performance reviews for CNS-B and ULP-D. O-A further stated licensee would not usually complete performance reviews on their employees unless there was a need for one. In addition, O-A stated licensee would take employee performance reviews into consideration. The licensee's Employee Evaluation policy dated March 25, 2024, indicated the employee	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 5 evaluation process at [licensee's] facility would be conducted in a manner which promoted the concepts of continuous improvement and frequent interaction between employees and their supervisors. Furthermore, the supervisor would use a standard evaluation form created by [licensee] and would complete a written administrative evaluation for each employee based on the employee's job description, goals, and objectives mutually agreed upon by the employee and the supervisor at the last evaluation. In addition, the evaluation form would be signed by the supervisor and the employee, with the original signed form placed in the employee's personnel file, and a copy of the completed and signed form would be given to the employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 6 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all required content. This had the potential to affect two residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's EP plan dated March 25, 2024, lacked the following requirements: - EP plan reviewed and updated annually; - EP policies reviewed and updated annually; - written communication plan reviewed annually; - sharing information on occupancy/needs; - missing resident plan reviewed quarterly; - develop policy and procedures which address	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 7 development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; and - must conduct and document exercises to test the EP plan at least twice per year including unannounced staff drills using the EP plan. On January 20, 2026, at 1:58 p.m., owner (O)-A stated licensee lacked the information noted above. O-A further stated licensee was supposed to review the EP every year and would be reviewing the EP plan this month. In addition, O-A stated he was unaware the missing person plan was required to be reviewed quarterly. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated April 25, 2024, indicated [licensee] had in place an effective and compliant Emergency Preparedness Plan. Furthermore, the intent was that the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. In addition, the plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
0 690	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for one of two residents (R2). 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: R2's service plan dated September 3, 2025, indicated R2 received services which included bi-weekly medication set-up by the registered nurse (RN), medication administration by the RN or home health aide (HHA) as prescribed, housekeeping services, laundry services, stand-by assistance with ambulation, meal set-up, behavior monitoring, and obtaining daily blood pressure. R2's medication administration record (MAR) dated January 2026, indicated staff assisted R2 with medication administration four times daily and as needed. The MAR included staff initials for medication administration that appeared to be those of unlicensed personnel (ULP)-C, ULP-D, and owner (O)-A. The documentation lacked authentication for ULP-D and O-A, with the full name and title of the person who documented in	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
0 690	Continued From page 9 R2's record. On January 21, 2026, at 2:45 p.m., O-A stated it must have been an oversight to ensure all staff who had administered medication put their name, initials, and title on the MARs. The licensee's undated Medication Management-Administration and Set-Up policy indicated the nursing staff and unlicensed personnel trained to provide medication administration at [licensee's] facility would document any medication administration provided accurately in each resident record. Furthermore, a licensed nurse would correctly and accurately document any medication setup provided. In addition, if initials were being used on a MAR, then a signature page would be used that included the person's name, title, signature, and initials located in an accessible place as verification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 775 SS=D	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 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 10 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 11 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 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).	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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 12 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01060	Continued From page 13 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the resident, legal representative, and designated representative with all required content related to an emergency relocation for one of one resident (R1). 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) 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: R1 was admitted to the licensee on January 10, 2024, and began receiving assisted living services.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01060	Continued From page 14 R1's service plan dated January 10, 2024, indicated R1 received services which included bi-weekly medication set-up by the licensed practical nurse (LPN) or registered nurse (RN), medication administration by the certified nursing assistant (CNA) or home health aide (HHA), housekeeping services, laundry services, stand-by assistance with ambulation, meal set-up, behavior monitoring, and obtaining daily blood pressure. R1's progress note dated November 13, 2025, indicated R1 complained of severe weakness, and staff noted R1 appeared lethargic, so 911 was called and R1 was sent to the hospital. R1's After Visit Summary dated November 13, 2025, indicated R1 was admitted to the hospital on November 12, 2025, for generalized weakness, likely due to low blood sugar in the setting of alcohol use, and discharged back to licensee on November 13, 2025. R1's record lacked evidence that the resident was provided with a written notice that contained, at a minimum: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after relocation, the resident	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01060	Continued From page 15 has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. R1's record lacked evidence that the above written notice was delivered as soon as practicable to: - the resident; - for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. On January 21, 2026, at 12:00 p.m., licensed assisted living director (LALD)-A stated when licensee's residents are sent to the hospital, they usually only stay for one day. LALD-A further stated licensee had notified the police regarding R1's hospitalization. Moreover, LALD-A stated he was unaware of all the required content that needed to be completed when a resident was sent to the hospital. The licensee's Emergency Relocation policy dated July 19, 2023, indicated licensee would in the event of an emergency relocation, [licensee] would provide a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01060	Continued From page 16 expected to return to the facility, or a statement that a return date is not currently known, and; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. Furthermore, the notice required would be delivered as soon as practicable to: - the resident; - the resident's legal representative; - the resident's designated representative; - if the resident was receiving home and community-based services, the resident's case manager; and - if the resident was relocated and had not returned to the licensee within four (4) days, the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to initiate a temporary service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01630	Continued From page 17 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: R2 was admitted to the licensee on September 2, 2025, and began receiving assisted living services. R2's record included an admission assessment dated September 2, 2025. R2's medication administration record (MAR) dated September 1, 2025, through September 30, 2025, indicated that on September 2, 2025, the registered nurse (RN) completed a bi-weekly medication set-up. R2's MAR dated September 1, 2025, through September 30, 2025, indicated that on September 2, 2025, owner (O)-A administered one (1) medication to R2 at 4:00 p.m., and four (4) medications to R2 at 8:00 p.m. R2's service plan dated September 3, 2025, and signed by R2 on September 5, 2025, indicated R2 received services which included bi-weekly medication set-up by the registered nurse (RN), medication administration by the RN or HHA as prescribed, housekeeping services, laundry services, stand-by assistance with ambulation, meal set-up, behavior monitoring, and obtaining daily blood pressure. R2's record lacked a temporary service plan prior to providing assisted living services.	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311		
(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
01630	Continued From page 18 On January 21, 2026, at 10:45 a.m., O-A stated he was unaware R2 was required to have a temporary service plan in place prior to services being started. O-A further stated he was under the impression licensee had 14 days to complete the service plan after R2's admission; therefore, that was why it had not been completed until September 3, 2025. Licensee's Service Plan policy dated July 19, 2023, indicated all residents receiving assisted living services would have a service plan in place. Furthermore, within 14 days after the date that services were first provided to a resident, [licensee] would finalize a written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup by the registered nurse (RN) included all the required content for two of two residents (R1, R2).	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311			
(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
01770	Continued From page 19 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) 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: During the entrance conference on January 20, 2026, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which included bi-weekly medication setup by the RN for their residents. R1 R1's service plan dated January 10, 2024, indicated R1 received services which included bi-weekly medication set-up by the licensed practical nurse (LPN) or RN, medication administration by the certified nursing assistant (CNA) or home health aide (HHA). On January 20, 2026, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-C prepare and administer oral and sublingual (under the tongue) medications to R1. R1's medication administration record (MAR) dated January 2026, indicated the RN would set-up R1's medications bi-weekly. The MAR included illegible staff initials for medication set-up. The documentation of medication set-up lacked authentication with the full name and title of the RN who documented in the record, and lacked the following: - name of medication; - quantity of dose;	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311			
(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
01770	Continued From page 20 - times to be administered; - route of administration; and - name of person completing medication setup. R2 R2's service plan dated September 3, 2025, indicated R2 received services which included bi-weekly medication set-up by the RN, medication administration by the RN or HHA as prescribed. On January 20, 2026, at 12:15 p.m., surveyor observed ULP-C prepare and administer oral medication to R2. R2's MAR dated January 2026, indicated the RN would set-up R2's medications bi-weekly. The MAR included illegible staff initials for medication set-up. The documentation of medication set-up lacked authentication with the full name and title of the RN who documented in the record, and lacked the following: - name of medication; - quantity of dose; - times to be administered; - route of administration; and - name of person completing medication setup. On January 21, 2026, at 2:45 p.m., O-A stated that licensee only had one nurse on staff who completed medication set-up; therefore, there would be no question as to who completed the medication set-up for the residents. The licensee's Medication Documentation policy dated August 1, 2021, indicated the licensee would document medication setup according to the following: -date of medication setup; -name of medication;	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER KEKELI CARE CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 18315 82ND PLACE NORTH MAPLE GROVE, MN 55311			
(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
01770	Continued From page 21 -quantity of dose; -times to be administered; -route of administration; and -name/title of person completing medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			



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

Kekeli Care Center
18315 82nd Place N
Maple Grove, MN 55369
Hennepin County
Parcel:

Phone:

License Info

License: 0042509

Risk:
License: -1
Expires on: 12/31/2024
CFPM: ASLAM M. JAMAL
CFPM #: FM121713; Exp: 01/04/2027

Inspection Info

Report Number: F8087261011
Inspection Type: Full - Single
Date: 1/20/2026 Time: 2:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 5-200A Plumbing: approved materials/design

5-201.11B Priority Level: Priority 3 CFP#: 51

MN Rule 4626.1040B Maintain the plumbing system in good repair.

COMMENT: KITCHEN SINK FAUCET IS LEAKING. OWNERSHIP HAS PURCHASED A NEW FAUCET BUT IS WAITING FOR THE PLUMBER TO COME AND INSTALL THE NEW UNIT.

Comply By: 1/27/2026 Originally Issued On: 1/20/2026

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT

FLOORS: LINOLEUM - NON COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: SAMSUNG

DISHWASHER: SAMSUNG

STOVE/RANGE: SAMSUNG

MICROWAVE: SAMSUNG

HAND WASHING SINK: YES - LEFT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

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

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE

PUCK USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087261011 from 1/20/2026

John Boettcher

FOLLY DOSSEVI
OWNER

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Kekeli Care Center
Maple Grove
County/Group: Hennepin County

Inspection Info

Report Number: F8087261011
Inspection Type: Full
Date: 1/20/2026
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at -12 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 34 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE; Temperature Process: Cold-Holding

Location: Upright Cooler at 35 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT; Temperature Process: Cold-Holding

Location: Upright Cooler at 34 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39446016-0	Date: 1/21/2026
Facility Name: KEKELI CARE CENTER LLC	
Facility Address: 18315 82nd Pl N, Maple Grove, Minnesota 55311	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Two (2) 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. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: Resident room 1 had a multiplug adaptor that did not comply with NFPA 70.

☒ **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 fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]
2. 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: Owner (O)-A stated no resident policy was in place at the time of the survey.

Comments: O-A stated that staff training was done on a third-party online platform and not on the licensee's written FSEP.

3. 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: O-A stated they train during evacuation drills but did not have documentation verifying the training was completed.