GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2025

Kelsey Kennedy
KnL Services LLC
8716 South River Rd
Cheboygan, MI 49721

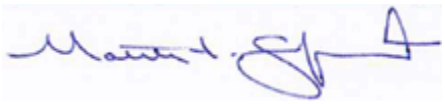
RE: License #: AS160419004
Kennedy Haven
521 Stempky Street
Cheboygan, MI 49721

Dear Mr. Kennedy:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license and special certification is renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (517) 335-5985.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AS160419004
Licensee Name:	KnL Services LLC
Licensee Address:	8716 South River Rd Cheboygan, MI 49721
Licensee Telephone #:	(701) 641-6472
Licensee/Licensee Designee:	Kelsey Kennedy
Administrator:	Lynn Kennedy
Name of Facility:	Kennedy Haven
Facility Address:	521 Stempky Street Cheboygan, MI 49721
Facility Telephone #:	(701) 641-6472
Original Issuance Date:	01/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED
Certified Programs:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 07/23/2025

Date of Bureau of Fire Services Inspection if applicable: N/A

Date of Health Authority Inspection if applicable: N/A

No. of staff interviewed and/or observed 2
No. of residents interviewed and/or observed 3
No. of others interviewed Role:

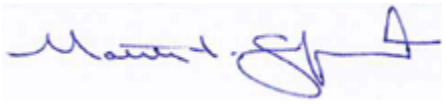
- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☐ No ☒ If no, explain.
  no meal service during inspection
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐
  If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s:
  N/A ☒
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

IV. RECOMMENDATION

I recommend issuance of a 2 year regular adult foster care license.



7/25/25

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Matthew Soderquist Date
Licensing Consultant