



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2026

Licensee
Providence Villa LLC
200 Minnesota Avenue East
Sebeka, MN 56477

RE: Project Number(s) SL34011016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 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 . . ."

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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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 that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2026
NAME OF PROVIDER OR SUPPLIER PROVIDENCE VILLA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MINNESOTA AVENUE EAST SEBEKA, MN 56477		
(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 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: SL34011016-0 On August 25, 2026, through August 27, 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 fifteen 15 resident(s);15 receiving services under the 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 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.		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 680	Continued From page 1 (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 develop an emergency preparedness plan (EPP) with all required content. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680			

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0 680	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2026, at 12:21 p.m., the surveyor requested the facility's emergency preparedness plan and related documentation. The licensee's undated EPP did not include the following: -an updated mutual agreement of understanding with [name] to use as a temporary relocation in the event of an emergency; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - a medical record documentation system to preserve resident information, security; - development of arrangements with other facilities and providers to receive residents if needed; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On August 26, at 9:12 a.m., maintenance manager (MM)-D stated the licensee had not renewed updated contracts with other facilities and had been working on getting the EPP updated with all required content. MM- D stated the EPP was in the process of being updated. The licensee's Emergency Preparedness Plan-	0 680			

Minnesota Department of Health

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0 680	Continued From page 3 Appendix Z Compliance policy revised August 17, 2026, indicated the licensee was responsible for maintaining an effective and current emergency preparedness plan and implementing procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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 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	0 775			

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0 775	Continued From page 4 August 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) 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 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	0 810			

Minnesota Department of Health
STATE FORM 6899 C8I411 If continuation sheet 6 of 15

Minnesota Department of Health

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01470	Continued From page 6 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470			

Minnesota Department of Health

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01470	Continued From page 7 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing to include all the required topics with records reviewed. 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: ULP-E had a hire date of January 29, 2026, and began providing services under the licensee's Assisted Living license.	01470			

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01470	Continued From page 8 ULP-E's employee record lacked the following required orientation content: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - infection control training. On August 26, 2026, at approximately 11:05 a.m., clinical nurse supervisor (CNS)-B confirmed ULP-E had not completed the required training and ULP-E's employee records lacked the above noted required orientation content. CNS-B stated the Residex training courses were assigned to ULP-E. On August 26, 2026, at approximately 11:22 a.m., CNS-B stated ULP-E had been removed from the work schedule until he completes his assigned required training. The licensee's Orientation of Staff and Supervisors and Content policy dated August 2021, indicated all licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided.	01470			

Minnesota Department of Health

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01470	Continued From page 9	01470			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia, mental illness, and de-escalation training in the required areas for one of three employees (unlicensed professional (ULP)-E). 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: During the entrance conference on August 25, 2026, at 12:28 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents in the employee record.	01490			

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01490	Continued From page 10 ULP-E began employment on January 29, 2026, to provide direct care services to residents and supervision of staff. ULP-E's employee record lacked evidence of completing dementia, mental illness, and de-escalation training in the following topics: -person centered planning and service delivery. -recognizing symptoms of common mental illness diagnose including but not limited to mood disorders, anxiety disorders, trauma and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse. -de-escalation techniques and communication. -crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. On August 26, 2026, at 1:30 p.m., LALD-A stated ULP-E had not completed training after his date of hire. On August 26, 2026, at 1:39 p.m., CNS-B provided a Residex (electronic medical record) for ULP-E. CNS-B stated ULP-E did not have all the required training. The licensee's Dementia Training policy dated August 1, 2024, indicated direct-care staff will complete eight (8) hours of initial education within 160 working hours of employment start date in the following topics: -an explanation of Alzheimer's Disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery.	01490			

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01490	Continued From page 11 The licensee's Mental Health Training policy dated August 1, 2025, indicated all direct care staff will complete 2 hours of initial training within 160 of employment start date in the following topics: -recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorders, and substance misuse. -de-escalation techniques and communication. -crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490			
01620 SS=E	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	01620			

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01620	Continued From page 12 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 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 a registered nurse (RN) completed a 14 day assessment after admission, and a comprehensive reassessment	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2026
NAME OF PROVIDER OR SUPPLIER PROVIDENCE VILLA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MINNESOTA AVENUE EAST SEBEKA, MN 56477		
(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
01620	Continued From page 13 not to exceed 90 days for two of three residents (R2, R3). 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 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). The findings include: R2 R2's record lacked evidence of a 14-day assessment completed by a RN after admission dated May 5, 2026. R2's diagnoses included Alzheimer's disease late onset. R2's service plan dated May 4, 2026, indicated R2 received services which included medication administration, assistance with bathing, grooming, dressing, incontinent cares, housekeeping, laundry, meals, and activities. On August 26, 2026, at approximately 12:43 p.m., unlicensed personnel (ULP)-C was observed administering R2's and R3's scheduled medications On August 27, 2026, at approximately 8:45 a.m., clinical nurse supervisor (CNS)-B confirmed she had not completed a 14 day reassessment due May 19, 2026, for R2 and verified R2's last comprehensive assessment was completed June	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2026
NAME OF PROVIDER OR SUPPLIER PROVIDENCE VILLA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MINNESOTA AVENUE EAST SEBEKA, MN 56477		
(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
01620	Continued From page 14 3, 2026. R3 R3's record lacked evidence of a 90-day assessment completed by a RN. R3's diagnoses include muscle weakness, age related osteoporosis. R3's service plan dated August 13, 2026, indicated R3 received services which included medication administration, assistance with bathing, grooming, and dressing, incontinent cares, housekeeping, laundry, meals, and activities. On August 26, 2026, at approximately 9:00 a.m., CNS-B confirmed R3's 90-day comprehensive reassessment was not completed. The most recent comprehensive assessment was completed on August 2, 2026, and prior to that, 166 days had passed since the previous assessment on January 15, 2026. CNS-B stated she was working on completing timely assessments. The licensee's Assessments, Reviews, and Monitoring policy dated December 10, 2021, indicated ongoing resident reassessments and monitoring must be conducted within 14 days upon admission, as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			



Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

PROVIDENCE VILLA
200 Minnesota Ave E
Sebeka, MN 56477
Wadena County
Parcel:

Phone:

License Info

License: HFID 34011

Risk:
License:
Expires on:
CFPM: Barbara M Huhta
CFPM #: 124467; Exp: 8/11/2027

Inspection Info

Report Number: F1065261110
Inspection Type: Full - Single
Date: 8/26/2026 Time: 10:45:17 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: AN INTERNAL THERMOMETER IS NEEDED IN THE UPRIGHT COOLER. DISCUSSED WITH STAFF.

Comply By: 8/27/2026 Originally Issued On: 8/26/2026

Food & Beverage General Comment

1. The Certified Food Manager should be routinely conducting self-inspections to ensure that employees are following proper food handling practices.
2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up-to-date employee illness log.
3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.
4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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 Fergus Falls District Office inspection report number F1065261110 from 8/26/2026

Monique Erickson

Establishment Representative

Monique Erickson,
Public Health Sanitarian 2
218-332-5146
monique.erickson@state.mn.us



Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
PROVIDENCE VILLA	Report Number: F1065261110
Sebeka	Inspection Type: Full
County/Group: Wadena County	Date: 8/26/2026
	Time: 10:45:17 AM

Equipment Temperature: Product/Item/Unit: ; **Temperature Process:** Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No



Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537

Sanitizer Observations/Recordings

Establishment Info	Inspection Info
PROVIDENCE VILLA	Report Number: F1065261110
Sebeka	Inspection Type: Full
County/Group: Wadena County	Date: 8/26/2026
	Time: 10:45:17 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** 3-Compartment Sink

Location: Dishwashing Area **Equal To** 100 PPM

Comment:

Violation Issued?: No

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

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34011016	Date: 8/26/2026
Facility Name: Providence Villa	
Facility Address: 200 Minnesota Ave. E. Sebeka, MN 56477	

☒ 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. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

Comments: The smoke alarms provided in the resident rooms throughout the facility lacked documentation of proper certification. The smoke alarms provided in resident rooms and throughout the facility did not display indication that they were tested or rated to underwriter laboratories (UL) standard 217. Facility staff could not provide documentation of proper listing for these devices and a review of the user manual failed to illustrate the required UL 217 certification to ensure smoke alarm durability and operability in an emergency situation. All smoke alarms should be properly listed to UL 217.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The plan was provided by a third party and included the R.A.C.E. acronym. The FSEP referenced fire doors and magnetic holders which this facility did not have.

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

Comments: The fire safety and evacuation plan did not include procedures necessary for residents. It referred to staff directing the residents on what to do in case of a fire emergency, but no guidance was given to residents for these procedures.