DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D947
Facility ID: 00150

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245449**

2. STATE VENDOR OR MEDICAID NO. (L2) **649240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SEMINARY HOME**
(L4) **906 COLLEGE AVENUE**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2012**

6. DATE OF SURVEY **07/07/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **84** (L18)

13. Total Certified Beds **84** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE
Robyn Woolley, HFE NE II
Date: 07/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Kate JohnsTon, Program Specialist
Date: 07/19/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/30/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245449
July 19, 2016

Mr. Jacob Goering, Administrator
Seminary Home
906 College Avenue
Red Wing, MN 55066

Dear Mr. Goering:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 7, 2016 the above facility is certified for or recommended for:

84 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2016

Mr. Jacob Goering, Administrator
Seminary Home
906 College Avenue
Red Wing, MN 55066

RE: Project Number S5449026

Dear Mr. Goering:

On May 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 10, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 7, 2016 and therefore remedies outlined in our letter to you dated May 19, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992   Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245449		7/7/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/07/2016	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 06/07/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 06/07/2016
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 06/07/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/07/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 07/19/2016	SIGNATURE OF SURVEYOR 20810	DATE 07/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245449	A. Building 01 - MAIN BUILDING 01 B. Wing	6/10/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0014	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0017	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 06/07/2016
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 06/07/2016
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 06/07/2016
ID Prefix Reg. # NFPA 101 LSC K0070	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0073	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 06/07/2016
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 06/07/2016	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 07/19/2016	SIGNATURE OF SURVEYOR 37008	DATE 06/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D947
Facility ID: 00150

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2. STATE VENDOR OR MEDICAID NO. (L2) **649240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SEMINARY HOME**
(L4) **906 COLLEGE AVENUE**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2012**

6. DATE OF SURVEY **05/05/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **84** (L18)
13.Total Certified Beds **84** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NE II 06/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/15/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

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24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 06/30/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 19, 2016

Mr. Jacob Goering, Administrator
Seminary Home
906 College Avenue
Red Wing, Minnesota 55066

RE: Project Number S5449026

Dear Mr. Goering:

On May 5, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> Electronic Plan of Correction - **when a plan of correction will be due and the information to be contained in that document;**

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 14, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 14, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of

compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

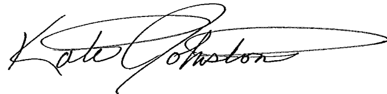
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE** **RED WING, MN 55066**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure activities of daily living were completed according to the individual care plan for 3 of 4 residents (R88, R8, R72) requiring staff assistance in the areas of ambulation, shaving, oral care, positioning and/or toileting needs Findings include: Ambulation: R88's care plan, revised on 4/13/16, directed staff	F 282	1. Residents #8 and #72, and #88 Care plans were reviewed. Revisions made and are appropriate/accurate at this time. Corresponding updates have been made to care assignment sheets. Education and/or counseling has been provided for staff members regarding the following plan of care. 2.Each resident is assessed for ADL s and ability to perform ADL s on admission, quarterly and/or with a significant change in condition as	6/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/27/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

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to ambulate R88 with the assist of one, to and from meals. However, on the morning of 5/4/16, R88 was not offered the opportunity to walk to and from the breakfast meal.

On 5/4/16, at 7:20 a.m. R88 was wheeled to the dining room from the West unit and was not ambulated. At 9:17 a.m. licensed practical nurse (LPN)-C approached R88 and asked if R88 would like to return to the bedroom to use the restroom. R88 was not asked about ambulating at this time and was wheeled back to the room.

On 5/4/16, at 11:54 a.m. LPN-C stated she thought the resident was walked "bid with nursing." At 1:30 p.m. nursing assistant (NA)-D verified R88 had not been ambulated to the breakfast meal, as staff had not had time to complete the ambulation. NA-D stated being aware that R88 was to ambulate to and from all meals.

On 5/5/16, at 9:15 a.m. R88 was observed wheeling from the dining room down the hallway to their room. No attempt to ambulate R88 was observed.

Shaving, oral care, positioning/toileting:

R8 was assessed as moderately impaired cognition with aphasia on 4/19/16, according to the care area assessment (CAA).

R8's plan of care, dated 8/1/14, directed staff, "Potential for alteration in communication R/T (related to) aphasia. Resident is able to communicate using 1-2 word sentences and gestures. Resident has full upper dentures, lower

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determined by the RAI process and per facility policy. A comprehensive analysis and care planning is conducted as part of the process.

a.The related policy and procedures including ADL s and ability to perform ADL s are part of the Care Planning Process, and Individualized Care Plans and Care Cards are updated as necessary in real time.

3.Additional educational In-Services regarding following plan of care, including Na/R care cards and care plans will be conducted with all Nursing staff at staff meetings held on 5/19/16 and 5/20/16. Ongoing staff meetings to continue and appropriate 1:1 counseling as needed.

4.All residents care plans were reviewed and are appropriate for resident needs and preferences. Audits related to ADL s and ADL preference and care plans will be conducted by clinical leadership members weekly for Three to Four random residents a week x 4 weeks, then 5 random residents over the following four weeks. The results will be reported and reviewed in Quality Council monthly and recommendations from the Quality team will be followed.

The Director of Nursing or Designee is responsible for ongoing compliance of this plan Date of completion to be by 6/7/16.

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partial. He is dependent on staff for oral care. Grooming/Hygiene: extensive assist of 1."

R8 was not clean shaven and was not provided oral care.

During an observation on 5/2/16, at 3:00 p.m. R8 was sitting up in a recliner chair in the bedroom and appeared unshaven with whiskers/stubble hair growth to the face.

During observations on 5/4/16, at 7:07 a.m. until 11:29 a.m., R8 was sitting in the recliner chair. No staff went into the room to assist R8 with shaving.

When interviewed on 5/4/16, at 12:23 p.m. nursing assistant (NA)-A and NA-B verified they did not shave or provide oral care for R8 because the night shift got him up and they thought the night shift provided the grooming. NA-A and NA-B validated R8 needed to be shaved.

In addition, R8's care plan, dated 4/20/16, directed staff, "Resident is incontinent of B&B (bowel and bladder) he does not request toileting and is unaware when incontinence occurs. He is dependent on staff for all cares and mobility. Hx (history) of UTI's (urinary tract infections). Check and change q2h (every 2 hours) and prn (whenever necessary) Provide incontinence care after each incontinent episode."

The plan of care also directed staff, "Resident is at risk for skin breakdown/pressure ulcers R/T (related to) limited mobility, B&B (bowel and bladder) incontinence, hx MASD (maceration) buttocks. Turn and reposition every 2 hours and prn (whenever necessary)

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R8 was not checked and changed for incontinence and did not receive a position change every two hours according to the plan of care.

During continuous observation on 5/4/16, at 7:07 a.m. until 11:29 a.m. four hours and 22 minutes, R8 was sitting in the recliner chair. No staff had gone into the room to address offloading or position change for pressure relief to buttocks.

Nursing assistant (NA)-A was interviewed on 5-4-16 at 11:29 a.m. to ask when would R8 be offered a position change or offloading. NA-A verified there had been no offers to offload and stated, "He will tell us when he needs to be changed so we don't do him until after lunch."

When interviewed on 5/4/16, at 12:23 p.m. nursing assistant NA-A and NA-B verified they did not offer a check and change for incontinence or a position change because the resident did not ask for the services.

R72 was assessed on 2/3/16, as cognitively intact according to the care area assessment (CAA).

R72's plan of care, dated 11/21/14, directed staff, "Resident has his own teeth in good repair, he is dependent on staff for oral hygiene. Resident will have oral hygiene BID (twice a day) et (and) prn (whenever necessary) Resident is dependent on staff for cares and Grooming/Hygiene: extensive assist of 1."

R72 was not clean shaven, and was not provided oral care.

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During an observation and interview on 5/2/16, at 7:00 p.m. R72 was sitting up in the wheel chair and had a heavy accumulation of whiskers/stubble present. R72 expressed he doesn't always get shaved or oral care every day because it depends on who gets him up and how much time they have. R72 expressed a preference to be shaved everyday and to have oral care done every day.

During continuous observations of care for R72 on 5/4/16, from 6:45 a.m. until 12:42 p.m. there were no offers for oral care or shaving.

When interviewed on 5/4/16, at 12:45 p.m. NA-A and NA-B revealed another team member floated over to the unit to help out today because of a team member being late, and did not have time to do the shaving and oral care because they had to get back to the other unit that they were assigned to.

R72's plan of care, dated 11/21/14, directed staff, "Resident is limited in ability to toilet self R/T (related to) impaired mobility, weakness, he is incontinent of B&B (bowel and bladder) Check and change q2h (every 2 hours) et prn (and whenever necessary). Peri care after incontinent episodes."

The plan of care for R72, dated 11/9/15, directed staff, "Resident is at risk for pressure ulcers/skin breakdown R/T impaired mobility, incontinence. Turn and reposition q2hr et prn. keep clean and dry as possible. Minimize skin exposure to moisture.

R72 was not checked and changed for incontinence and did not receive a position

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F 282	Continued From page 5 change every two hours according to the plan of care. During continuous observations of care for R72 on 5/4/16, from 6:45 a.m. until 12:42 p.m. there were no offers for incontinence check or position changes from the staff. When interviewed on 5/4/16, at 12:45 p.m. NA-A and NA-B revealed another team member floated over to the unit to help out today because of a team member being late, and verified they did not offer a check and change for incontinence or a position change because the resident did not ask for the services. When interviewed on 5/4/16, at 1:19 p.m. licensed practical nurse (LPN)-A verified R8 and R72 are to be clean shaven everyday and oral care performed twice a day. R8 and R72 are to be checked and changed for incontinence and to have their position changed every two hours.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R88, R8, R72) received the appropriate treatment and services to maintain the ability to ambulate (R88); as well as shave and do oral care with minimal assistance (R8, R72.)	F 311	1.Residents #8,#72, and #88 Care plans were reviewed. Revisions made and are appropriate/accurate at this time. Corresponding updates have been made to care plan and assignment sheets focusing on maintaining ADL s related to	6/7/16

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Findings include:

A form dated 1/29/16, titled Walking Program Functional Skills Instruction Sheet identified R88 was to ambulate to and from all three meals.

A nurses note dated 3/10/16, indicated the nurse practitioner ordered a physical therapy assessment to consider a functional maintenance program; and an occupational therapy assistant note dated 4/15/16, indicated R88 had been screened and was on an ambulation program. The care plan, revised on 4/13/16, indicated R88 required limited to extensive assistance of 1-2 and a walker to ambulate to and from meals.

On the morning of 5/4/16, R88 was not offered the opportunity to walk to and from the breakfast meal.

On 5/4/16, at 7:20 a.m. R88 was wheeled to the dining room from the West unit and was not ambulated. At 9:17 a.m. licensed practical nurse (LPN)-C approached R88 and asked if R88 would like to return to their room and use the restroom. R88 was not asked about ambulating at this time and was wheeled R88 back to the room.

On 5/4/16, at 11:54 a.m. LPN-C stated she thought the resident was walked "bid with nursing."

On 5/4/16, at 11:56 a.m. two nursing assistants were observed to assist R88 with ambulation. R88 walked from the bathroom to the doorway in their room and then sat down in the wheelchair. The nursing assistants attempted ambulation again in the hallway leading to the dining room.

resident needs and resident choice. Education and/or counseling has been provided for staff members regarding the following plan of care.

2.Each resident is assessed for ADL s and ability to perform ADL s on admission, quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process.

a.The related policy and procedures including ADL s and ability to perform ADL s are part of the Care Planning Process, and Individualized Care Plans and Care Cards are updated as necessary in real time.

3.Additional educational In-Services regarding following plan of care, including Na/R care cards and care plans will be conducted with all Nursing staff at staff meetings held on 5/19/16 and 5/20/16. Ongoing staff meetings to continue and appropriate 1:1 counseling as needed.

4.All residents care plans were reviewed and are appropriate for
resident needs and preferences. Audits related to ADL s and ADL preference and care plans will be conducted by clinical leadership members weekly for Three to Four random residents a week x 4 weeks, then 5 random residents over the following four weeks. The results will be reported and reviewed in Quality Council

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F 311	Continued From page 7 R88 ambulated approximately eight feet with a walker and gait belt before stating "my knees aren't working" and sat down in the wheelchair, which the second nursing assistant was pushing behind the resident. At 1:30 p.m. nursing assistant (NA)-D verified R88 had not been ambulated to the breakfast meal. NA-D stated being aware R88 was to ambulate to and from all meals. On 5/5/16, at 9:15 a.m. R88 was observed wheeling from the dining room down the hallway to their unit. No attempt to ambulate the resident was observed. A review of documents titled Point of Care History, dated 4/1 to 4/30/16, and 5/1-5/4/16, revealed R88 was not being consistently ambulated to and from meals. The documents identified R88 ambulated from one to three times a day during the time frame from 4/13/16 to present. R8, during an observation on 5/2/16, at 3:00 p.m., was sitting up in a recliner chair in the bedroom and appeared unshaven with whiskers/stubble hair growth to the face. When interviewed on 5/2/16, at 3:58 p.m. family member (F-A) expressed concern regarding the cares for R8 and stated, "Staff are not good about brushing his teeth. I am not happy about the care, his face is often dirty, and he isn't shaved everyday. I don't think they have enough staff to take care of all the people." During an observation on 5/4/16, at 7:25 a.m. R8	F 311	monthly and recommendations from the Quality team will be followed. The Director of Nursing or Designee is responsible for ongoing compliance of this plan Date of completion to be by 6/7/16.	

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F 311	Continued From page 8 was sitting up in the recliner chair watching television. R8 said he had not been shaved and did not have oral cares completed. R8 had visible whiskers/stubble hair growth to the face. When interviewed on 5/4/16, at 12:23 p.m. nursing assistant (NA)-A and NA-B verified they did not shave or provide oral care for R8 because the night shift got him up and they thought the night shift provided the grooming. NA-A and NA-B validated R8 needed to be shaved. R8 was assessed as moderately impaired cognition with aphasia on 4/19/16, according to the care area assessment (CAA). Document review of the plan of care for R8 dated 8/1/14, read "Potential for alteration in communication R/T (related to) aphasia. Resident is able to communicate using 1-2 word sentences and gestures. Resident has full upper dentures, lower partial. He is dependent on staff for oral care. Grooming/Hygiene: extensive assist of 1." R72 was not clean shaven, and was not provided oral care. During an observation and interview on 5/2/16, at 7:00 p.m. R72 was sitting up in the wheel chair and had a heavy accumulation of whiskers/stubble present. R72 expressed he doesn't always get shaved or oral care every day because it depends on who gets him up and how much time they have, but that R72 would prefer to be shaved everyday and to have oral care done every day. During continuous observation of care for R72 on 5/4/16, from 6:45 a.m. until 12:42 p.m. there were	F 311		

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no offers for oral care or shaving from the staff.

When interviewed on 5/4/16, at 12:45 p.m. NA-A and NA-B revealed another team member floated over to the unit to help out today because of a team member being late, and did not have time to do the shaving and oral care because they had to get back to the other unit that they were assigned to.

R72 was assessed on 2/3/16, as cognitively intact according to the care area assessment (CAA).

Document review of the plan of care for R72 dated 11/21/14, read, "Resident has his own teeth in good repair, he is dependent on staff for oral hygiene. Resident will have oral hygiene BID (twice a day) et (and) prn (whenever necessary) Resident is dependent on staff for cares and Grooming/Hygiene: extensive assist of 1."

The facility policy dated October 2010 titled, Shaving the Resident, read; "The purpose of this procedure is to promote cleanliness and to provide skin care. Notify the supervisor if the resident refuses the care."

The facility policy dated October 2010, titled, Teeth, Brushing, read; "The purposes of this procedure {sic} are to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums and to remove food particles from between the teeth. Notify the supervisor if the resident refuses the procedure."

When interviewed on 5/4/16, at 1:19 p.m. licensed practical nurse (LPN)-A verified R8 and

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F 311	Continued From page 10 R72 are to be clean shaven everyday and oral care performed twice a day.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 2 of 2 residents (R8, R72) in the sample who were dependent upon staff for personal care. Findings include: R8 did not receive every two hour brief checks for incontinence. During an observation on 5/2/16, at 3:00 p.m. R8 was sitting up in a recliner chair in the bedroom watching television. Various observations on 5/2/16, revealed R8 sitting in the recliner chair throughout the shift, including eating supper in the bedroom in the recliner chair. When interviewed on 5/2/16, at 3:58 p.m. family member (F-A) expressed concern regarding the cares for R8 and stated, "Staff are not good about brushing his teeth. I am not happy about the care, his face is often dirty, and he isn't shaved everyday. I don't think they have enough staff to	F 312	1.Residents #8 and #72 were comprehensively re-assessed for pressure ulcer risk using Skin Risk Assessment with Braden Scale, and Tissue Tolerance Observation, and repeated Bowel and Bladder observation on 05/24/16 and it has been determined that care plan is accurate. 2.Each resident is assessed for B & B and pressure ulcer risk upon admission, quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process. 3.Additional educational In-Services regarding following plan of care, including Na/R care cards and care plans will be conducted with all Nursing staff at staff meetings held on 5/19/16 and 5/20/16. Ongoing staff meetings to continue and appropriate 1:1 counseling as needed.	6/7/16

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SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

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F 312	Continued From page 11 take care of all the people." Furthermore, F-A expressed frustration for R8 sitting long periods of time in the recliner chair without an opportunity to check and change for incontinence. During continuous observation on 5/4/16, at 7:07 a.m. R8 required the mechanical lift to transfer into the reclining chair in the bedroom. Feet elevated in the reclining chair. At 7:50 a.m. the dietary aide put the feet down and sat R8 up in the reclining chair for breakfast. At 8:37 a.m. the meal tray was removed and R8 was positioned with the feet up on the recliner chair. R8 was observed dozing on and off in the recliner chair with feet elevated. At 10:25 a.m. a volunteer arrived to play cards and assisted R8 putting the feet down in the recliner so R8 could sit up to play cards. At 11:29 a.m. four hours and 22 minutes, R8 continued to play cards sitting in the recliner chair. No staff had gone into the room to check for incontinence. Nursing assistant (NA)-A was interviewed on 5-4-16 at 11:29 a.m. to ask when would R8 be checked for incontinence. NA-A verified there had been no offers to check for incontinence and stated, "He will tell us when he needs to be changed so we don't do him until after lunch." NA-A said they would change him after lunch because everyone was going to lunch now. On 5/4/16, at 12:23 p.m. R8 finished lunch and NA-A and NA-B used the mechanical device to put R8 to bed. R8 had deep red craters and crevices throughout the perineal and buttock area from the brief and clothing wrinkling. R8's brief was heavily saturated with urine. R8 expressed being happy to lay in the bed and have the brief changed.	F 312	4.All residents care plans were reviewed and are appropriate for resident needs and preferences. Audits related to incontinence and managing incontinence will be conducted by clinical leadership members weekly for Three to Four random residents a week x 4 weeks, then 5 random residents over the following four weeks. The results will be reported and reviewed in Quality Council monthly and recommendations from the Quality team will be followed. The Director of Nursing or Designee is responsible for ongoing compliance of this plan Date of completion to be by 6/7/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ________ B. WING ________	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 312	Continued From page 12	F 312		

R8 was assessed as moderately impaired cognition with aphasia on 4/19/16, according to the care area assessment (CAA).

Document review of the plan of care for R8 dated 8/1/14, read "Potential for alteration in communication R/T (related to) aphasia. Resident is able to communicate using 1-2 word sentences and gestures. Resident is incontinent of B&B (bowel and bladder) he does not request toileting and is unaware when incontinence occurs. He is dependent on staff for all cares and mobility. Hx (history) of UTI's (urinary tract infections). Check and change q2h (every 2 hours) and prn (whenever necessary) Provide incontinence care after each incontinent episode."

R72 did not receive every two hour brief checks for incontinence.

During an observation on 5/2/16, at 7:32 p.m. R72 was complaining of sitting up in the wheel chair for a very long period of time and complained of pain in the buttock region. R72 said no one had checked him for incontinence since early afternoon.

During continuous observation on 5/4/16, at 6:45 a.m. R72 was positioned in the wheel chair with a mechanical device. At 7:33 a.m. R72 was able to wheel himself to the dining room for breakfast. At 8:20 a.m. R72 remained in the wheel chair and was watching television in the bedroom. At 9:45 a.m. R72 appeared to be dozing sitting in the wheel chair and the television was on. At 11:12 a.m. licensed practical nurse (LPN)-A brought in a diuretic medication and said R72 had the diuretic medication at 8 a.m. as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 312	Continued From page 13	F 312		

Continued From page 13

Nursing assistant (NA)-A was interviewed on 5-4-16 at 11:29 a.m. to ask when would R72 be checked for incontinence. NA-A verified there had been no offers to check for incontinence and stated, "He will tell us when he needs to be changed so we don't do him until after lunch."

On 5/4/16, at 12:42 p.m. R72 and NA-A and NA-B used the mechanical device to put R72 to bed. R72 had deep red craters and crevices throughout the perineal and buttock area from the brief and clothing wrinkling. R72's brief was heavily saturated with urine. R72 expressed being happy to lay in the bed and have the brief changed and perineal cleansing.

R72 was assessed on 2/3/16, as cognitively intact according to the care area assessment (CAA).

Document review of the plan of care for R72 dated 11/21/14, read, "Resident is limited in ability to toilet self R/T (related to) impaired mobility, weakness, he is incontinent of B&B (bowel and bladder) Check and change q2h (every 2 hours) et prn (and whenever necessary). Peri care after incontinent episodes."

Document review of the facility policy titled, Urinary Continence and Incontinence-Assessment and Management, dated October 2010, read; Management of incontinence will follow relevant clinical guidelines. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 312	Continued From page 14 When interviewed on 5/4/16, at 1:19 p.m. licensed practical nurse (LPN)-A verified R8 and R72 were to be checked and changed for incontinence every two hours and to receive perineal cleansing after each incontinence.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 2 of 2 residents (R8 & R72) in the sample identified at risk for pressure ulcers. Findings include: R8 did not receive every two hour repositioning. During an observation on 5/2/16, at 3:00 p.m. R8 was sitting up in a recliner chair in the bedroom watching television. Various observations on 5/2/16, revealed R8 sitting in the recliner chair throughout the shift, including eating supper in the bedroom in the recliner chair.	F 314	1.Residents #8 and #72 were comprehensively reassessed for pressure ulcer risk using Skin Risk Assessment with Braden Scale, and Tissue Tolerance Observation on 05/24/16 and it has been determined that care plan is accurate. 2.Each resident is assessed for pressure ulcer risk upon admission, quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process. a.The related policy and procedures including Skin Risk Assessment/Turning and Repositioning, Skin Integrity-Pressure	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE** **RED WING, MN 55066**

(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) COMPLETION DATE
F 314	Continued From page 15 When interviewed on 5/2/16, at 3:58 p.m. family member (F-A) expressed frustration for R8 sitting long periods of time in the recliner chair without an opportunity to change position. During continuous observation on 5/4/16, at 7:07 a.m. R8 required the mechanical lift to transfer into the reclining chair in the bedroom. Feet elevated in the reclining chair. At 7:50 a.m. the dietary aide put the feet down and sat R8 up in the reclining chair for breakfast. At 8:37 a.m. the meal tray was removed and R8 was positioned with the feet up on the recliner chair. R8 was observed dozing on and off in the recliner chair with feet elevated. At 10:25 a.m. a volunteer arrived to play cards and assisted R8 putting the feet down in the recliner so R8 could sit up to play cards. At 11:29 a.m. four hours and 22 minutes, R8 continued to play cards sitting in the recliner chair. No staff were observed to go into the room to address offloading or position change to relieve pressure for buttocks. Nursing assistant (NA)-A was interviewed on 5-4-16 at 11:29 a.m. to ask when would R8 be offered a position change or offloading. NA-A verified there had been no offers to offload and stated, "He will tell us when he needs to be changed so we don't do him until after lunch." This surveyor informed NA-A R8's buttocks would need to be observed due to sitting up for so long. NA-A said they would change him after lunch because everyone was going to lunch now. On 5/4/16, at 12:23 p.m. R8 finished lunch and NA-A and NA-B used the mechanical device to put R8 to bed. R8 had deep red craters and crevices throughout the perineal and buttock area	F 314	Sores, Treatments, Care Planning Process, and Individualized Care Plans and Care Cards were reviewed and revised on May 24, 2016. 3.Additional educational In-Services regarding following plan of care, including Na/R care cards and care plans will be conducted with all Nursing staff at staff meetings held on 5/19/16 and 5/20/16. Ongoing staff meetings to continue and appropriate 1:1 counseling as needed. 4.All residents care plans were reviewed and are appropriate for resident needs and preferences. Audits related to ADL s and off-loading potential areas of pressure will be conducted by clinical leadership members weekly for Three to Four random residents a week x 4 weeks, then 5 random residents over the following four weeks. The results will be reported and reviewed in Quality Council monthly and recommendations from the Quality team will be followed. The Director of Nursing or Designee is responsible for ongoing compliance of this plan Date of completion to be by 6/7/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 314	Continued From page 16	F 314		

Continued From page 16

from the brief and clothing wrinkling. R8 expressed being happy to lay in the bed and have the position changed.

R8 was assessed as moderately impaired cognition with aphasia on 4/19/16, according to the care area assessment (CAA).

Document review of the plan of care for R8 dated 4/20/16, read "Potential for alteration in communication R/T (related to) aphasia. Resident is able to communicate using 1-2 word sentences and gestures. Resident is at risk for skin breakdown/pressure ulcers R/T (related to) limited mobility, B&B (bowel and bladder) incontinence, hx MASD (maceration) buttocks. Turn and reposition every 2 hours and prn (whenever necessary)

R72 did not receive every two hour position changes.

During an observation on 5/2/16, at 7:32 p.m. R72 was complaining of sitting up in the wheel chair for a very long period of time and complained of pain in the buttock region. R72 said no one had offered a position change since early afternoon.

During continuous observation on 5/4/16, at 6:45 a.m. R72 was positioned in the wheel chair with a mechanical device. At 7:33 a.m. R72 was able to wheel himself to the dining room for breakfast. At 8:20 a.m. R72 remained in the wheel chair and was watching television in the bedroom. At 9:45 a.m. R72 appeared to be dozing sitting in the wheel chair and the television was on. At 11:12 a.m. licensed practical nurse (LPN)-A brought in a diuretic medication and said R72 had the diuretic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 314	Continued From page 17	F 314		

medication at 8 a.m. as well.

Nursing assistant (NA)-A was interviewed on 5-4-16 at 11:29 a.m. to ask when would R72 have a position change NA-A verified there had been no offers to change position and stated, "He will tell us when he needs to be changed so we don't do him until after lunch." This surveyor informed NA-A R72's buttocks would need to be observed due to sitting up for so long. NA-A said they would change him after lunch because everyone was going to lunch now.

On 5/4/16, at 12:42 p.m. R72 and NA-A and NA-B used the mechanical device to put R72 to bed. R72 had deep red craters and crevices throughout the perineal and buttock area from the brief and clothing wrinkling. R72's brief was heavily saturated with urine. R72 expressed being happy to lay in the bed and have the brief changed and perineal cleansing.

R72 was assessed on 11/5/16, as cognitively intact according to the care area assessment (CAA) and was assessed as at risk for skin breakdown.

Document review of the plan of care for R72 dated 11/9/15, read, "Resident is at risk for pressure ulcers/skin breakdown R/T impaired mobility, incontinence. Turn and reposition q2hr et prn. keep clean and dry as possible. Minimize skin exposure to moisture.

Document review of the facility policy titled, Repositioning, dated May 2013, read;Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure

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	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

(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) COMPLETION DATE
F 314	Continued From page 18 relief. Residents who are in a chair should be on an every one hour (q1h) repositioning schedule. When interviewed on 5/4/16, at 1:19 p.m. licensed practical nurse (LPN)-A verified R8 and R72 were to have their position changed at least every two hours.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure 1 of 1 resident (R82) in the sample identified as frequently incontinent of urine, was assessed to assure appropriate treatment and services were implemented to minimize urinary incontinence. Findings include: A bladder assessment dated 3/7/16, identified R82 was continent of urine, however, the initial Minimum Data Set, dated 3/14/16, identified R82 as frequently incontinent of urine and required extensive assistance of one person to transfer	F 315	1.Resident 82 is no longer in the building and discharged while survey was in the building. 2.Each resident is assessed for continence of Bowel and Bladder upon admission over a 3 day study, then again quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process. a.All residents who exhibit urinary	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

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F 315	Continued From page 19 and use the toilet. A care plan was developed on 3/24/16, indicating R82 had frequent bladder incontinence, and required extensive assist of one person to toilet, "on demand." The initial MDS also identified R82's Brief Interview for Mental Status (BIMS) score as 14/15. Interview with nursing assistant (NA)-F and review of a care card dated 3/24/16, did not identify toileting needs for R82. It did not direct staff that R82 was frequently incontinent, that extensive assistance with transferring was required, that although R82 was to be taken to the toilet "on demand", R82 did not consistently ask to be taken to the toilet and R82's incontinent product was frequently wet, when checked or toileted. During interview on 5/2/16, at 5:44 p.m. R82 was asked about toileting needs. R82 stated did not always get help to use the toilet and explained that when there is no help, " I wet in my brief." At 5:45 p.m. R82 turned the call light on and it was answered by nursing assistant (NA)-H. When NA-H answered the call light R82 told NA-H that the incontinent brief needed to be changed. NA-H asked if it needed to be changed at this time and although R82 stated "No", NA-H did not offer to take R82 to the toilet or make an attempt to change the incontinent brief. At 5:50 p.m. R82 turned the call light on again and told NA-I the incontinent brief was wet. R82's wet incontinent brief was changed, however R82 was not offered the opportunity to use the toilet. At 6:18 p.m. NA-H was interviewed and verified R82's incontinent brief had been wet. When asked why NA-H had not offered to take R82 to	F 315	incontinence will have plan of care developed to avoid incontinence and a loss of dignity and will be toileted according to plan of care. 3.Additional educational In-Services regarding following plan of care, including Na/R care cards and care plans will be conducted with all Nursing staff at staff meetings held on 5/19/16 and 5/20/16. Ongoing staff meetings to continue and appropriate 1:1 counseling as needed. 4.All residents care plans were reviewed and are appropriate for resident needs and preferences. Audits related to managing bladder incontinence and toileting rlated to care plans will be conducted by clinical leadership members weekly for Three to Four random residents a week x 4 weeks, then 5 random residents over the following four weeks. The results will be reported and reviewed in Quality Council monthly and recommendations from the Quality team will be followed. The Director of Nursing or Designee is responsible for ongoing compliance of this plan Date of completion to be by 6/7/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE RED WING, MN 55066**

(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) COMPLETION DATE
F 315	Continued From page 20 the toilet, NA-H stated R82 was difficult to transfer. On 5/4/16, at 7:05 a.m. R82 was observed being taken to the dining room for breakfast. Nursing assistant (NA)-F was asked at this time which cares had been completed for R82. NA-F stated all cares, except oral, which would be done after breakfast. When asked if R82 had been toileted, NA-F stated R82 did not ask use the toilet. NA-F explained that R82 will ask to use the toilet during the day, but had increased urinary incontinence at night. At 8:21 a.m. R82 was taken from the dining room back to the bedroom by licensed practical nurse (LPN)-C and transferred from the wheelchair into a recliner. R82 was not asked by LPN-C if R82 needed to use the toilet and R82 did not ask to use the toilet. At 8:37 a.m. R82 put the call light on and when answered by NA-G, R82 asked to use the toilet. With a transfer belt, and assist of two nursing assistants, R82 was transferred from the w/c to the toilet and voided on the toilet. When NA-G was asked if the incontinent brief was wet or dry, NA-G stated the brief was wet. At 9:02 a.m. a follow up interview was conducted with NA-F who had completed morning cares on R82 before breakfast. When asked what the conditon of R82's incontinent brief had been that morning, NA-F stated it had been wet. NA-F stated sometimes R82's incontinent brief was wet even when the resident indicated needing to use the toilet.	F 315		

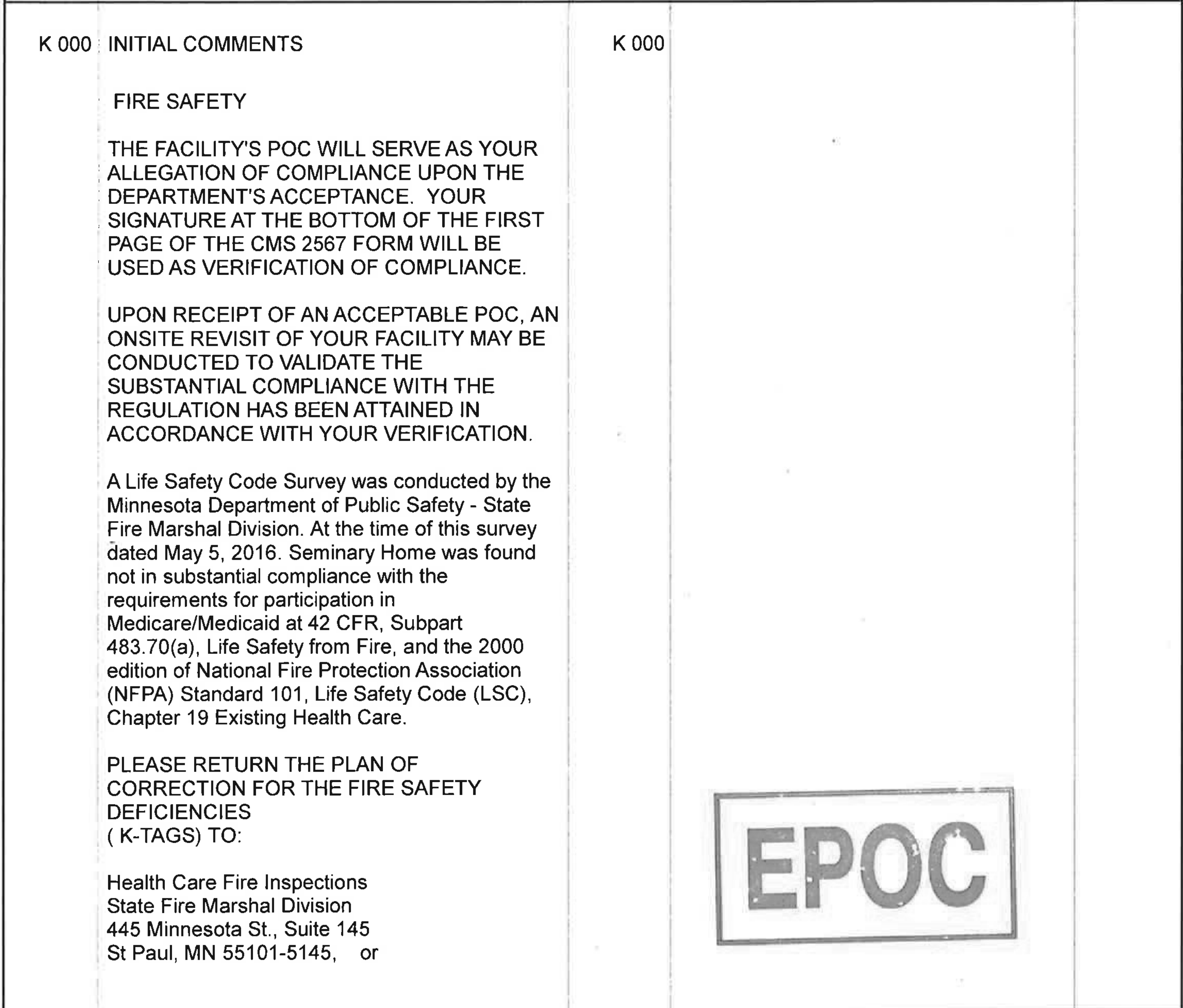
PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5449081

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated May 5, 2016. Seminary Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/27/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE** **RED WING, MN 55066**

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Seminary Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958 and was determined to be of Type II(111) construction. In 1966 & 1975 an addition(s) was constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a licensed capacity of 84 beds and had a census of 74 at the time of the survey.

The requirement at 42 CFR Subpart 483.70(a) is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

(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) COMPLETION DATE
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 014 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 This STANDARD is not met as evidenced by: Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1.Carpet was found on lower half of residents rooms doors in Friendship wing east and west. 2. Wood paneling was found in dining area without flame spread documentation. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 014	1. Flame spread rating documentation A. Carpet on doors: 10.2,19.3.3.1, 19.3.3.2, NFPA TIA 00-2 obtained for carpet on the lower half of resident room doors in the Friendship east and west wings. B. Wood Paneling 10.2,19.3.3.1, 19.3.3.2, NFPA TIA 00-2 obtained forwood paneling in the dining area. 2. Actual completion date 18 May 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1.There is physical therapy equipment was	K 017	1. Physical therapy equipment that was obstructing a fire exit has been removed and stored properly. 2. Actual completion date 11 May 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	6/7/16

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K 017	Continued From page 4 obstructing exit corridor. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018	1. The double-doored linen closets in Bluffview will have hardware installed that will self-latch and hold the doors closed. Room 2C Education door was fixed on 23 May 2016. 2. To be completed by 17 June 2016. 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of	6/7/16

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K 018	Continued From page 5 door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1.Double doors for storage by main offices corridor need to self latch in close position. 2.Room 2C education door does not latch positional when tested. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 018	recurrence.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	K 025	1. Fire barrier sealant caulk will be installed around pipes in SW corridor smoke barrier. 2. To be completed by 7 June 2016 3. Nicole Anderson, Director of Environmental Services is responsible	6/7/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE** **RED WING, MN 55066**

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K 025	Continued From page 6 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. A penetration was found in SW corridor through smoke barrier around water pipes. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 025	for correction and prevention of recurrence.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. Employee exit door does not have code posted for exiting on door. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 038	1. A door code has been posted by the employee entrance key-pad. 2. Completed 23 May 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and monitoring to prevent recurrance.	6/7/16
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an	K 056		6/7/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 056	Continued From page 7 approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. There is storage in the crawl space that is non-sprinklered. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 056	1. Items stored in the crawls space have been removed. 2. To be completed by 7 June 2016. 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		6/7/16

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K 062	Continued From page 8 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. Need to supply (2) two of every type of fire sprinkler heads through-out faculty. 2. A.Room 32 file server needs 18" clearance from sprinkler head and has missing ceiling tiles. B.Room 110 Activity room is missing ceiling tiles. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 062	1. A: 2 sprinkler heads for each type are now in stock at facility. B: Items have been removed to allow 18" clearance of sprinkler head in Room 32. C. Missing cieling tile replaced. 2. A: Completed 16 May 2016 B: Completed 23 May 2016 C: Completed by 7 June 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066		6/7/16

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K 066	Continued From page 9 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. Provide smoking policy and add no smoking signage to all exit doors.	K 066	1. The smoking policy has been updated to include required language and "smoking prohibited" signs have been installed at all entrances. 2. Completion by 7 June 2016. 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	

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K 066	Continued From page 10 These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 066		
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. There was no report of the semi-annual hood system inspection. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 069	1. Semi-annual hood inspection was completed on 2 March 2016. 2. Completed 2 March 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	6/7/16
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found:	K 070	1. Portable electric fireplaces have been removed. 2. Completed 13 May 2016 3. Nicole Anderson, Director of Plant Services responsible for correction and prevention of reccurrence.	6/7/16

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K 070	Continued From page 11 1. Remove portable fireplace with heater in sitting area. These deficient practices were confirmed by the Facility Maintenance at the time of discovery	K 070		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. That is no documentation for flame resistance for curtains on ceiling in private dining area. These deficient practices were confirmed by the Facility Maintenance at the time of discovery	K 073	1. Flame retardent documentation has been obtained for private dining room curtains. 2. Completed 6 May 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	6/7/16
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1,	K 074		6/7/16

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K 074	Continued From page 12 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	K 074	1. Flame spread rating documntation has been obtained for privacy curtains. 2. Completed 6 May 2016 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 13 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. Drapes through-out facility did not have flame spread rating documentation. These deficient practices were confirmed by the Facility Maintenance at the time of discovery	K 074		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1. Provide copy of Natural Gas Generator backup fuel source letter from Gas Company. These deficient practices were confirmed by the Facility Maintenance at the time of discovery	K 144	1. A copy of Backup Gas Fuel Source Letter has been obtained from Excel Energy. 2. Completed 16 May 2016. 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	6/7/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in	K 147	1A Extension cord for generator	6/7/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY HOME	**906 COLLEGE AVENUE** **RED WING, MN 55066**

(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) COMPLETION DATE
K 147	Continued From page 14 accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 On facility tour between 9:30am and 3pm on 05/05/2016, observation revealed, that the the following was found: 1.Emergency light for generator room is plugged into extension cord. 2. Multi plug adapter is being used in break room for a number of appliance. 3. Electric fireplace is plugged into multi-plug adapter. These deficient practices were confirmed by the Facility Maintenance at the time of discovery	K 147	emergency light removed. 1B Multi-plug adapter removed from emploee break room. 1C Multi-plug removed with fireplace. 2. Completed by 7 June 2016. 3. Nicole Anderson, Director of Environmental Services is responsible for correction and prevention of recurrence.	