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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JKYO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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)

6. DATE OF SURVEY **11/12/2013** (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:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2013 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5449

A standard OTC survey was completed at this facility on August 1, 2013. The most serious deficiencies were cited at a S/S level of F.

In addition, on August 28, 2013, a FMS survey was completed and deficiencies were found, the most serious at a S/S level of F. On September 11, 2013, the CMS RO notified the facility of the following:

- Mandatory DOPNA, effective November 1, 2013

A PCR of the health deficiencies was completed September 13, 2013. A PCR of the LSC and FMS deficiencies was completed November 12, 2013. All of the deficiencies were found corrected. The facility was found in compliance as of October 31, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA, effective November 1, 2013, be rescinded.

This would also mean that the facility would not be subject to a loss of NATCEP.

See attached CMS-2567B forms.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5449 December 20, 2013

Mr. Jacob Goering, Administrator
Seminary Home
906 College Avenue
Red Wing, Minnesota 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 October 31, 2013 the above facility is certified 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245449	A. Building B. Wing	9/13/2013

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0325 Reg. # 483.25(i) LSC	09/05/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	09/09/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By SR/sd	Date: 12/20/13	Signature of Surveyor: 16022	Date: 09/13/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/1/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245449	A. Building B. Wing 01 - MAIN BUILDING 01	11/12/2013

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	09/21/2013	ID Prefix Reg. # NFPA 101 LSC K0143	08/30/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/sd	Date: 12/20/13	Signature of Surveyor: 25822	Date: 11/12/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/30/2013		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245449	A. Building B. Wing **01 - MAIN BUILDING 01**	11/12/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/31/2013**	ID Prefix	Correction Completed **09/21/2013**	ID Prefix	Correction Completed **10/31/2013**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **10/31/2013**	ID Prefix	Correction Completed **10/31/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0104		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	12/20/13	25822	11/12/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/28/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JKYO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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: **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 **08/01/2013** (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:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 09/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/27/2013 (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 9/27/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 20, 2013

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

RE: Project Number S5449022, F5449021 and F5449022

Dear Mr. Goering:

On August 15, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2013. 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.

In addition, on August 28, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found 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 September 11, 2013, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 1, 2013

Also, the CMS Region V Office notified you in their letter of September 11, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), if your facility failed to achieve substantial compliance by November 1, 2013, your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 1, 2013.

On September 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 12, 2013 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 August 1,

2013 and the FMS completed on August 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013 and the FMS completed on August 28, 2013, effective October 31, 2013. As a result of the PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of September 11, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 1, 2013 be rescinded.

In the CMS letter of September 11, 2013, you were advised that, in in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 1, 2013, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on October 31, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5449

At the time of the standard survey completed August 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3977

August 15, 2013

Ms. Mary Jo Hill, Administrator
Seminary Home
906 College Avenue
Red Wing, Minnesota 55066

RE: Project Number S5449022

Dear Ms. Hill:

On August 1, 2013, 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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
Minnesota Department of Health
P.O. Box 64900
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 September 10, 2013, 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 September 10, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 1, 2013 (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 February 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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:

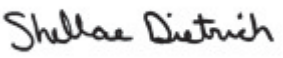
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5449s13,rtf

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 _____	08/01/2013

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. 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 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	Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor interventions for 1 of 2 residents (R59) who was identified at a nutritional risk and continued to lose weight. Findings include: The facility failed to monitor interventions for R59	F 325	9/3/13 SER	

RECEIVED
AUG 30 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Jo Hill | TITLE: Adm. | (X6) DATE: 8/28/13

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
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F 325	Continued From page 1 who was identified at a nutritional risk and continued to lose weight. R59 was readmitted to the facility on 5/30/13, with diagnoses of a femur fracture, dementia, palliative care, adult failure to thrive, and depressive disorder On 7/31/13 at 11:34 a.m., R59 was at lunch sitting at the table with staff assistance. R59 received a pureed lunch of roast beef, potatoes and a cabbage like salad. There were two cartons of thickened liquid plus a cup of chocolate-like substance. The nursing assistant (NA-A) feeding R59 indicated 30% of the lunch and 130 cc total of all fluids offered were consumed. The chocolate substance was not consumed and NA-A indicated it was a supplement. The significant change minimum data set (MDS), completed on 6/5/13, identified the resident as cognitively impaired, and needed extensive assist with eating. The resident's current wt was 147 lbs. The Care Area Assessment (CAA) for nutritional status read: "the resident with need for mech (mechanical) altered textures: Resident tolerating this well but intake is poor to fair usually. WT (weight) is overall stable. Goal of stability. Supplements in place. Will follow closely and make changes as needed." A review of the resident's weights were: 7/26/13: 136 pounds 6/22/2013: 143 (which is 7 lbs. less than on the first date or a 5.1% loss) 4/05/2013: 154 (which is 18 lbs. less than on the first date or a 13.2% loss) 1/04/2013: 158 (which is 22 lbs. less than on the	F 325	Resident #59 was reassessed for nutritional risk on August 16/2013, and Care plan updated. All Residents are assessed for nutritional risk upon admission, quarterly, and with significant change in condition. Seminary Home initiated a new program called High Risk Nutrition Meeting to identify and monitor residents who are at nutritional risk for weight loss. Resident's weights are monitored by the dietitian weekly, and reweights are asked to be obtained based on weight trending. Changes of significance are discussed in the High Risk nutrition meeting with the IDT on Thursday mornings at 9:30 with the Nurse Practioner present and any changes will be documented on by the RD/or IDT group. This High Risk Nutrition meeting was initiated on August 8th, 2013, The related policy and procedure for "Weight Monitoring and Documentation" was reviewed on August 1, and remains current.	

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F 325	Continued From page 2 first date or a 16.2% loss). The medical record indicated weights were monitored one time in June and one time in July. The nutritional assessment dated 6/5/13 and signed by the dietician, indicated the resident was receiving nutritional dietary supplements 120 cc six times daily. The resident ' s current weight was 147 down from 155 pounds. Intake of food and fluids at meals was 50% for food and adequate at fluids. The monitoring identified included labs as available, weights weekly, monitor intake supplements, and intake of food and fluids and follow up quarterly or as needed. The nutritional diagnostic statement read: "Resident at nutritional risk due to multiple medical problems and variable intake thus need for supplements, dysphasia noted, pureed diet with thicken liquids in place. Will follow closely. Monitor intake and tolerance of diet regime. On 7/29/137/29/13 the dietary progress note indicated resident with significant weight loss with poor intake, The nutritional dietary supplement was in place six times a day, resident received a pureed diet with thickened liquid. Resident was to receive fortify foods to maximize calorie and protein intake and offer snacks twice a day. Will offer magic cup with all meals. RD to follow. The dietary note lacked documentation of how much the resident was consuming of meals and of nutritional supplements. A progress note from the medical doctor dated 6/4/13 indicated resident not on hospice but comfort care, and indicated weight at 147.5 with being down 5 pounds in last two months per	F 325	Mandatory in-services with nursing staff on weight monitoring and nutritional risk identification will be held on September 4th and 5th, 2013. The Registered Dietitian and Certified Dietary Manager are responsible for ongoing compliance of this plan.	9/5/13

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F 325	Continued From page 3	F 325		

nursing. There was no further mention of weight loss in the note.

A progress note dated 7/10/13 by the nurse practitioner, indicated resident was positive for weight loss and for poor appetite. The report further indicated resident's weight at 134.5 a decrease in 8 pounds in last month, with weights being monitored weekly.

The current plan of care indicated resident would consume 50% of meals, resident a nutritional risk due to depression, constipation, poor intake, failure to thrive and significant weight loss. Interventions included nutritional supplements, and magic shake, hours of sleep snack and lab works. Interventions also included monitor/record weight and notify MD and family of significant weight change.

On 8/1/13 at 1:30 p.m. the culinary manager reviewed the food intake sheets for July and confirmed the resident was mostly consuming approximately up to 25 percent of meals and drinking less than 200 cc per meal. Only 8 times in July, was fluid intake greater than 240 cc per meal. The culinary manager also verified R59 was receiving a bed time snack, however, the manager had just ordered another flavor of pudding after learning R59 did not like the current flavor.

On 8/1/13 at 2:00 p.m. the registered dietician (RD) indicated R59 was at high risk for weight loss, but indicated the weight loss should be stopped with the interventions in place. The RD indicated high risk persons weight was monitored monthly and added additional weights should be available. The RD explained she had not notified

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F 325	Continued From page 4 the medical doctor, but worked with nursing. Documentation of amount of supplements and snacks were not obtained. On 8/1/13 at 2:10 p.m. the director of nursing (DON) reported the facility was unable to locate any documentation regarding the medical doctor or the nurse practitioner identifying the failure to thrive diagnoses or the weight loss. The DON verified weights were not being monitored weekly, and there were no additional weights available. The Weight Monitoring and Documentation Policy, effective 12/12 indicated in Step 6 of the procedure: "Licensed nursing staff is to verify the accuracy if the weight changes. Re-weighs are recommended for residents with a 5 pound or greater weight change. Number 7 B indicated "dietician/designee will meet with the licensed nursing staff to determine possible causes and intervention for resident with significant weight loss as well as for those at risk for unintended weight loss." No. 9 e last bullet indicated the Dietician will estimate calories actually consumed. Number 10 indicated physician and family will be notified of any significant weight change.	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 5 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide insulin that was not outdated for 7 of 14 insulin vials checked. This had the potential to affect eight residents who received insulin from those vials. Findings include: During medication storage observation on 7/29/13 at 5:50 p.m. the three medication carts were observed. Two of the carts had expired	F 431	All outdated insulin was discarded and new insulin's were opened, dated with expiration dates, and put in use on July 29, 2013 on the Bluffview Unit and East Unit. The influenza vaccine was discarded on July 31, 2013. The related policy and procedures "Medications with Shortened Expiration Dates" and "Expiration Dates of Medications" were reviewed and revised on August 1, 2013. Education was completed with licensed nursing staff during skills fair on August 8, 2013 and will be completed again at mandatory In-service with all Licensed staff on September 5, 2013. Audits related to expiration dates will be completed weekly x 4 weeks and then ongoing as determined by Quality Assurance. Director of Nursing or designee is responsible for the ongoing compliance of this plan.	9/9/13

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F 431	Continued From page 6 insulin that was being used by residents. On the Bluff unit all five insulins were outdated with four vials having the open dates of 6/27 and one 6/28. The five insulins were: two Novolog (insulin aspart) opened 6/27, two lantus opened 6/27, and one Novolog N opened 6/28. Licensed practical nurse (LPN-A), agreed the staff were using outdated insulin even though the LPN stated, "I just ordered those insulins on Friday." LPN-A indicated the staff had not started to use the new insulins and were using outdated insulins, because the newly ordered insulins were observed unopened in the refrigerator. The East unit medication cart was observed on 7/29/13 at approximately 6:15 p.m. and two of the nine insulins were out dated and still being utilized. Lantus insulin was opened on 5/26 and was still being used two months later. Novolog insulin was opened on 6/27. Registered nurse (RN)-A and licensed practical nurse (LPN)-B agreed the insulins were outdated and still being used for residents. New bottles of unopened insulin were found in the refrigerator. In addition 3 boxes of influenza vaccine, 2 which were full and one which had 5/10 vials in the box, had expired 6/30/13. RN-A indicated none had been given after the influenza season. The undated policy and procedure, entitled "Medications with Shortened Expiration Dates," revealed, "as recommended by the United States Pharmacopeia, expiration dating not specifically referenced in the package insert should not exceed 30 days once the vial has been opened." When interviewed on 7/31/13 at 11:45 a.m. the director of nursing (DON) verified the insulins	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 7 were outdated and should have been discarded. She also verified the influenza vaccine had not been used but should have been discarded.	F 431		

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 _____	**07/30/2013**

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	INITIAL COMMENTS	K 000		

RECEIVED
AUG 26 2013
MN DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

DC: 09-10-2013

EXIT: 08-01-2013

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, 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

POC ok
8-26-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Jo Hill	Adm.	8/21/13

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.

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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 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@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 partial fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 84 beds and had a census of 71 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Proposal will be obtained from certified contractors, approved & completed by September 30th, 2013. Fire Marshall will be contacted immediately upon completion for approval.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 1-6.2.1 . The deficient practice could affect all 65 residents. Findings include: During the facility tour between 1:30 and 4:00 PM on 07/30/2013, a new fire alarm control panel (FACP) was installed and an operational acceptance test was done on 4/2/2013. No Record of Completion for system was completed, do to duct detectors are not operating properly to shut down the air handlers. This deficient practice was confirmed by the	K 052		

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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 052	Continued From page 3 Facility Maintenance Director (TS) at the time of discovery.	K 052	Maintenance staff will cap duct work off above ceiling & will patch opening with 5/8 drywall. Work will be completed by August 30th, 2013.	
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure oxygen transfill room is vented as required by 1999 NFPA 99. The deficient practice could affect all 65 residents. Findings include: During the facility tour between 1:30 and 4:00 PM on 07/30/2013, observation revealed the 1st floor	K 143		

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 _____	**07/30/2013**

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 143	Continued From page 4 oxygen storage/transfill room # 125, has two exhaust vents (1) vent is vented directly outside and (1) vent that is vented back into building heating, ventilation, air and cooling (HVAC) system. Need to remove the vent that is exhausted back into building HVAC. This deficient practice was confirmed by the Facility Maintenance Director (TS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 143		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	08/01/2013

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 29, 2013 through August 1, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	08/01/2013

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

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.	2 965		

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	00150	A. BUILDING: _____ B. WING _____	08/01/2013

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SEMINARY HOME	906 COLLEGE AVENUE RED WING, MN 55066

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2 965	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor interventions for 1 of 2 residents (R59) who was identified at a nutritional risk and continued to lose weight. Findings include: The facility failed to monitor interventions for R59 who was identified at a nutritional risk and continued to lose weight. R59 was readmitted to the facility on 5/30/13, with diagnoses of a femur fracture, dementia, palliative care, adult failure to thrive, and depressive disorder On 7/31/13 at 11:34 a.m., R59 was at lunch sitting at the table with staff assistance. R59 received a pureed lunch of roast beef, potatoes and a cabbage like salad. There were two cartons of thickened liquid plus a cup of chocolate-like substance. The nursing assistant (NA-A) feeding R59 indicated 30% of the lunch and 130 cc total of all fluids offered were consumed. The chocolate substance was not consumed and NA-A indicated it was a supplement. The significant change minimum data set (MDS), completed on 6/5/13, identified the resident as cognitively impaired, and needed extensive assist with eating. The resident's current wt was 147 lbs. The Care Area Assessment (CAA) for nutritional status read: "the resident with need for mech (mechanical) altered textures: Resident tolerating this well but intake is poor to fair usually. WT (weight) is overall stable. Goal of stability.	2 965		

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2 965	Continued From page 3 Supplements in place. Will follow closely and make changes as needed." A review of the resident's weights were: 7/26/13: 136 pounds 6/22/2013: 143 (which is 7 lbs. less than on the first date or a 5.1% loss) 4/05/2013: 154 (which is 18 lbs. less than on the first date or a 13.2% loss) 1/04/2013: 158 (which is 22 lbs. less than on the first date or a 16.2% loss). The medical record indicated weights were monitored one time in June and one time in July. The nutritional assessment dated 6/5/13 and signed by the dietician, indicated the resident was receiving nutritional dietary supplements 120 cc six times daily. The resident ' s current weight was 147 down from 155 pounds. Intake of food and fluids at meals was 50% for food and adequate at fluids. The monitoring identified included labs as available, weights weekly, monitor intake supplements, and intake of food and fluids and follow up quarterly or as needed. The nutritional diagnostic statement read: "Resident at nutritional risk due to multiple medical problems and variable intake thus need for supplements, dysphasia noted, pureed diet with thicken liquids in place. Will follow closely. Monitor intake and tolerance of diet regime. On 7/29/137/29/13 the dietary progress note indicated resident with significant weight loss with poor intake, The nutritional dietary supplement was in place six times a day, resident received a pureed diet with thickened liquid. Resident was to receive fortify foods to maximize calorie and protein intake and offer snacks twice a day. Will offer magic cup with all meals. RD to follow. The	2 965		

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2 965	Continued From page 4 dietary note lacked documentation of how much the resident was consuming of meals and of nutritional supplements. A progress note from the medical doctor dated 6/4/13 indicated resident not on hospice but comfort care, and indicated weight at 147.5 with being down 5 pounds in last two months per nursing. There was no further mention of weight loss in the note. A progress note dated 7/10/13 by the nurse practitioner, indicated resident was positive for weight loss and for poor appetite. The report further indicated resident's weight at 134.5 a decrease in 8 pounds in last month, with weights being monitored weekly. The current plan of care indicated resident would consume 50% of meals, resident a nutritional risk due to depression, constipation, poor intake, failure to thrive and significant weight loss. Interventions included nutritional supplements, and magic shake, hours of sleep snack and lab works. Interventions also included monitor/record weight and notify MD and family of significant weight change. On 8/1/13 at 1:30 p.m. the culinary manager reviewed the food intake sheets for July and confirmed the resident was mostly consuming approximately up to 25 percent of meals and drinking less than 200 cc per meal. Only 8 times in July, was fluid intake greater than 240 cc per meal. The culinary manager also verified R59 was receiving a bed time snack, however, the manager had just ordered another flavor of pudding after learning R59 did not like the current flavor.	2 965		

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2 965	Continued From page 5 On 8/1/13 at 2:00 p.m. the registered dietician (RD) indicated R59 was at high risk for weight loss, but indicated the weight loss should be stopped with the interventions in place. The RD indicated high risk persons weight was monitored monthly and added additional weights should be available. The RD explained she had not notified the medical doctor, but worked with nursing. Documentation of amount of supplements and snacks were not obtained. On 8/1/13 at 2:10 p.m. the director of nursing (DON) reported the facility was unable to locate any documentation regarding the medical doctor or the nurse practitioner identifying the failure to thrive diagnoses or the weight loss. The DON verified weights were not being monitored weekly, and there were no additional weights available. The Weight Monitoring and Documentation Policy, effective 12/12 indicated in Step 6 of the procedure: "Licensed nursing staff is to verify the accuracy if the weight changes. Re-weighs are recommended for residents with a 5 pound or greater weight change. Number 7 B indicated "dietician/designee will meet with the licensed nursing staff to determine possible causes and intervention for resident with significant weight loss as well as for those at risk for unintended weight loss." No. 9 e last bullet indicated the Dietician will estimate calories actually consumed. Number 10 indicated physician and family will be notified of any significant weight change. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or	2 965		

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2 965	Continued From page 6 designee could develop and implement policies and procedures to ensure residents at nutritonal risk received appropriate interventions and follow up to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3977

August 15, 2013

Ms. Mary Jo Hill, Administrator
Seminary Home
906 College Avenue
Red Wing, Minnesota 55066

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5449022

Dear Ms. Hill:

The above facility was surveyed on July 29, 2013 through August 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5449s13lc.rtf