STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	03/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to readmit a resident after a leave of absence for 1 of 1 residents (R1). The facility implemented a policy after R1 had left the building on a leave of absence (LOA) and resulted in the resident's inability to return to the location during the COVID-19 Pandemic. Findings include: R1's Admission Record printed 3/30/20, identified primary [DIAGNOSES REDACTED]. R1 was listed as her own responsible party. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated she had clear speech, was understood, and understand others. The MDS further indicated R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The physician orders [REDACTED]. NO NARCOTICS. R1's plan of care dated 2/10/19, indicated R1 was a vulnerable adult and was at risk related to age, medical diagnosis, medication regime and need for placement. During an interview on 3/31/20, at 10:44 a.m. R1 stated that she had just gotten back to the facility on the evening of March 30, 2020. R1 stated that she had gone on a leave of absence (LOA) from the facility and the facility refused to let her come back in. R1 stated she received a text message dated 3/14/20, at 2:56 p.m. on her telephone stating: (R1), this is Rose of Sharon. It is extremely important that you be aware of the new protocols in place due to the Pandemic of the [MEDICAL CONDITION]. No outside visitors are allowed except when medically necessary as someone is at end of life. Since you are on a LOA, you will not be able to return into the building for 14 days and after having a negative COVID-19 test. If you have items i.e. medications, clothing, or other personal items from your room that are necessary, you are to call the building and have staff obtain these items for you and bring them outside to you. Please contact the nurse supervisor at Rose of(NAME)as soon as possible. R1 explained that when she could not get back into the building, she was able to call a girlfriend and stayed with her during her LOA. During an interview with the administrator on 3/31/20, at 1:19 pm. it was noted the guidelines for the pandemic COVID-19 changed. The administrator verified the 14 day guidelines changed on 3/13/20, after R1 had gone out on LOA. R1 had been informed via text message that she could not return to the facility during that time and she needed to have a negative COVID-19 test to return. The administrator further stated, We were going with what we had at the time, things are changing as we go and are learning about the situation. When asked about the Guidelines For Return document, dated by R1, 3/30/20, section g., the administrator did indicate, yes; if a resident were to go on an LOA during this shelter-in-place order, they would be considered an against medical advice (AMA) discharge. The administrator then clarified it may depend on what the reasons for going out were and who it may be; explaining each case may need to be considered independently. During a record review (progress notes (PN) and LOA book) on 3/31/20, at 3:00 p.m., R1 was noted out of the building on LOA on 3/4/20, at 10:23 a.m., and returned 3/5/20, at 1:40 a.m. R1 left the building again on 3/5/20, prior to supper time and did not sign out; R1 returned 3/6/20, at 2:25 a.m. On 3/6/20, at 10:42 p.m. R1 left the building and was visually seen returning on 3/7/20, at 12:21 p.m. She again returned from LOA on 3/7/20, at 10:25 p.m. R1 returned to the facility on [DATE], at 00:58 a.m. to obtain medications and left again 00:24 a.m. R1 was noted to be sleeping in her bed on 3/10/20, at 1:22 p.m. A PN dated 3/13/20, at 3:00 p.m. (late entry), indicated R1's family member was in the building after the facility had limited visitors due to the pandemic. The PN also indicated the administrator went to discuss the changes with R1 and the need for family to leave when R1 became upset and began swearing. The PN indicated R1 called her family member and stated we need to leave, (they're) f***ing kicking us out, we need to go. Shortly after this, R1 and a family member left the building without signing out. R1's PN further indicated that R1 remained out of the building on 3/14/20, at 4:27 p.m A PN indicated on 3/14/20, at 2:56 p.m. the administrator sent a text message to R1 phone with the information that she cannot return to the facilty within 14 days and a negative COVID-19 test. A PN dated 3/14/20 at 3:00 p.m., indicated a facility staff person had a telephone conversation with R1, who verbalized understanding that she would not be allowed back into the building for 14 days and until R1 had a negative COVID-19 test. A PN dated 3/19/20, entry time 9:17 a.m, Late entry note indicated the facility had gotten a call from Allina Clinic. (R1) had been asking for a negative COVID-19 test which she needed to return back to the facility. According to the PN, the Allina Clinic nurse explained that the facility would pay for R1's hotel stay and would bring medications and food to her two times a day. The facility staff explained this was not correct and R1 should call the facility. On 3/19/20, at 1:25 p.m. via text messaging R1 indicated she did want the bed held, stating have no where to go. On 3/30/20, at 8:12 p.m. R1 returned to the facility, having been out 18 days. A letter dated 3/10/20, addressed to residents and family members, stated Rose of(NAME) A Villa Center was Ensuring residents are cared for in a safe and healthy environment is our greatest concern. Further, the letter limited visitors, stating they were following recommendations of the CDC on prevention steps. A letter signed by the administrator, dated 3/19/20, to families and loved ones, indicated new information was coming related to the pandemic and the facility would continue to follow recommendations such as social distancing and offered ways to connect to patients such as window visits, Facetime, Skype. The letter included a Frequently Asked Questions, updated 3/16/20, version 3.0 was provided to staff, family, residents. A letter from Minnesota Elder Justice Center dated 3/19/20, indicated the facility texted R1 on 3/14/20, telling her she could not return to the building for 14 days and after having a negative COVID-19 test. In the letter, the Minnesota Elder Justice Center advised R1 on legal remedies to this illegal lock-out provided under MN504B.2312. A letter dated 3/20/20, from Rose of(NAME)to Minnesota Elder Justice Center, indicated on 3/13/20, after R1 chose to leave the center, the facility implemented further emergency measures intended to protect the residents and staff in the center from potential exposure. While (R1) was out of the building, she had been advised of the implementation of this emergency measure. A letter dated 3/24/20, from the Southern Minnesota Regional Legal Services, indicated they planned to file an illegal lockout petition on 3/25/20, on behalf of (R1). This letter further stated, (R1) was not appropriately appraised of changes happening at the facilty and your office has not taken other reasonable measure to ensure that (R1) is safe. This letter further explained the official COVID-19 policy of Rose of(NAME) stated they will place residents from hospitals with confirmed cases of COVID-19, where they will remain under observation for 14 days. A letter dated 3/25/20, from the facility to Southern Minnesota Regional Legal Services stated: we must act in the manner deemed necessary by the spread of COVID-19 and the imminent threat that it places to all residents in our center . (R1) will be permitted back in the center on March 28, 2020. A document Guidelines for (R1) to return from Leave of Absence (LOA) dated 3/30/20, g. Resident will follow Minnesota's current Shelter-In-Place order March 30th-April 13th, 2020. If resident leaves the building during this order it will be considered an AMA discharge. The guidelines given to patients related to the LOA implemented on 3/13/20, was requested and not provided.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a safe and sanitary living environment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) was provided for 1 of 7 residents (R2) reviewed for infection control at the time of the COVID-19 Focused Infection Control Survey. Findings include: R2's [DIAGNOSES REDACTED]. R2's significant change Minimum Data Set ((MDS) dated [DATE], indicated R2 was cognitively intact and needed extensive assistance with bed mobility, transfers, locomotion on unit, dressing, toileting and hygiene. The MDS also indicated R2 had an indwelling catheter. R2's care plan dated 2/20/20, directed staff to follow infection control practices for catheter cares. During an observation on 3/31/20, at 10:55 a.m. the door to R2's room was open halfway and a droplet precautions sign was on the door. R2's foley catheter drainage bag was observed to be laying on the floor. During an interview at this time, NA-A stated typically the catheter bags were hung on the edge of the bed or in a privacy bag. NA-A got a privacy bag out of R2's closet and put the drainage bag in it and hung it on the edge of the bed frame. During an interview on 3/31/20, at 3:08 p.m. with the director of nursing (DON) and corporate nurse consultant registered nurse (RN)-A, RN-A stated the expectation for catheter drainage bags was to have it kept off the floor and hung up on beds or wheelchairs. The facility protocol Catheter Care (undated) lacked direction where to place foley catheter drainage bags.