Electronically delivered
October 14, 2020

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

RE: CCN: 245342
Cycle Start Date: September 29, 2020

Dear Administrator:

On September 29, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 28, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 28, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 28, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Greeley Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 28, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 March 29, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT GREELEY LLC	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on September 28, & 29, 2020, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On September 28, & 29, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5342054C, with a deficiency cited at F580, & F655. A COVID-19 Focused Infection Control survey was also conducted September 28, & 29, 2020, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2020

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 000	Continued From page 1 acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		10/20/20

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F 580	Continued From page 2 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to report a significance of a change in condition for 1 of 3 residents (R1) reviewed for condition change of dark stool, increased weakness and new incontinence. The failure of the facility to inform the physician of a three day decline resulted in harm for R1 when hospitalized with a critical low hemoglobin (Hgb protein in red blood cells that carries oxygen from the lungs to the rest of the body) and required blood transfusions. Findings include: R1's initial admission Minimum Data Set (MDS) dated 8/24/20, indicated R1 had moderate cognitive impairment, with diagnoses which included anemia, cerebral vascular accident (CVA) and malnutrition.	F 580	Resident (R1) was discharged to the hospital and did not return to the facility. As a result, we were not able to validate the resident□s admitting diagnosis. It was a family member that diagnosed him with a CVA. Staff□s documented information did not support that diagnosis. Nursing staff were re-educated on the importance of: -monitoring for changes in resident condition -Notification of MD/NP with all pertinent information -Improving assessment and documentation skills -Assess, validate and document information reported to them by any other staff member with reporting tools -Listening to and sharing with the MD/NP	

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F 580	Continued From page 3 R1's document review of interdisciplinary progress notes (IPN) dated 8/13/20, at 11:22 a.m. indicated a lab value for a Hgb of 6.1 grams per deciliter (normal value 13.8 to 17.2 g/dL) and the physician ordered R1 to be sent to the hospital for evaluation and blood transfusion. R1 was admitted to the hospital and returned to the facility on 8/17/20 with a Hgb of 8.2 post blood transfusions. R1's IPN dated 9/14/20, read, "Continent of bowel and bladder for the most part, uses the urinal independently." R1's IPN dated 9/20/20, at 1:08 p.m. registered nurse (RN-A) documented, "NAR [nursing assistant registered] reported to writer that resident is feeling weak." There was lack of follow up assessment or vital signs noted in chart. R1's IPN's dated 9/20/20, at 9:53 p.m. RN-B documented, "Pt informed family [F-A] who came to visit at the window that [R1] thought [R1] had a stroke earlier in the day, when Pt experienced weakness. Stroke assessment initiated per [F-A's] request, no S/sx [signs/symptoms] of stroke noted. Pt had elevated temp up to 102.0 temporal artery, temp was 98.3 orally and 98.5 auxiliary. Ice pack applied to forehead, will continue to monitor. Vs [vital signs] 114/60, 102.0, 20 68, 93 RA [room air]." RN-B did not document the stool color. R1's IPN's dated 9/21/20 at 1:14 a.m. read, Writer [RN-B] called the on call provider to report a change in condition and the on call ordered a chest X-ray and lab work. At 5:43 a.m. RN-B documented, "Pt's temp fluctuated all night, temp via temporal artery down to 100.0, orally 98.6.	F 580	families wishes for hospitalization Facility Policy, Change in Conditions, was reviewed and remains current. The DON or designee will review progress notes and assessment forms 3x□s weekly for complete and accurate documentation. The DON or designee will randomly interview NAR□s to obtain information they have communicated to nurses and then review the chart for appropriate documentation. The DON or designee will audit all hospital discharge charts for appropriate assessment, MD/NP, family notification documentation Audits will be conducted weekly for 6 weeks, every other week for 2 months and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. LNHA/designee is responsible for compliance	

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F 580	Continued From page 4	F 580		

PRN [whenever necessary] Tylenol and cough syrup administered. Pt increased anxiety and restlessness noted, asking for ice chips and using cup of water for oral swabs for drinking. Pt also had urinal on mouth, writer intervened and removed it from mouth," The documentation did not address dark stools or a three day decline with new incontinence.

R1's IPN dated 9/21/20, at 9:14 a.m. indicated the writer received a call from the lab that R1's Hgb was 4.7 g/dL which was reported to the physician who order R1 to be sent to the emergency room via EMS (emergency medical services). R1 was admitted to the hospital on 9/21/20, with dx of critically low hemoglobin and required blood transfusions.

When interviewed on 9/25/20, at 2:17 p.m. F-A stated on 9/20/20, at sometime between 8:30 - 9:00 p.m. through the window during an outside closed window visit, "I spoke with the nurse [RN-B] and told [RN-B] [R1] was worse, probably a stroke, why was the left eye drooping and they needed to send [R1] into the hospital, I asked the nurse to do a stroke assessment and find out why [R1] was so weak and this is a big change in condition. The nurse told me there was nothing to be concerned about and everything was fine. I told that nurse to send [R1] 911 to the hospital and they did not do it. We aren't allowed in the facility because of Covid but I knew there was a big change [R1] was too weak to even talk and the nurse did not listen when I said send [R1] 911 to the hospital. I left crying I was so upset that the nurse wouldn't listen to me, I could see something was very wrong. The hospital did tell me [R1] had another stroke and [R1] was bleeding internally, critical low of blood and

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F 580	Continued From page 5	F 580		

needed transfusions and the nurse would not listen to me that something was very wrong. I was so upset"

When interviewed on 9/28/20, at 10:55 a.m. nursing assistant (NA-A) stated, "[R1] needed encouragement to get up and get motivated, [R1] the last three days wasn't walking, the strength went down hill, [R1] was incontinent, would spill the urinal, [R1's] stools were dark, usually not that dark, I reported it to [RN-A] but was told that was iron deficiency, I reported the dark stools, nurses were aware of his stools, they said it was normal for [R1]."

When interviewed on 9/28/20, at 1:15 p.m. certified nurse practitioner (CNP) indicated [R1] was complex with a severe stroke in July, seen by neurology and on multiple anticoagulation at that time. The CNP indicated iron supplements could change the color of the stool but it would have been prudent for the nurse to report to the on call physician the fact that the nursing assistant thought there had been a deterioration for the past three days especially weakness, increased lethargy, incontinence and stool darkening in color. Furthermore, the CNP stated, "In light of the information from the nursing assistant pertaining to the change in bowel movement color and increased lethargy and change to incontinence, and the family insisting on an evaluation, it would have been prudent to inform the NP of those facts and I probably would have sent [R1] to the ER for evaluation right away."

When interviewed on 9/28/20, at 1:24 p.m. RN-A verified [NA-A] reported that [R1] was weak and not feeling good, and being incontinent but did not recall if [NA-A] reported the stool was darker than

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F 580	Continued From page 6 usual. When interviewed on 9/28/20, at 1:32 p.m. the director of nursing (DON) verified now knowing that the NA-A reported 9/20/20, at 1:08 p.m. the change in [R1's] condition to the nurse should have prompted the nurse to evaluate the diagnosis of anemia and the Hgb of 6.1 g/dL in August which required hospitalization for blood transfusions would be information the on call physician should have been made aware of. Furthermore, the DON verified the family wishes to send to the ER due to stroke concerns should have been reported to the physician. When interviewed on 9/28/20, at 1:57 p.m. physician for R1 verified importance to listen to the family concerns and as a team the information the nursing assistant shared was important for the on call physician to have been made aware of to help in determining the change in condition of a patient. When interviewed on 9/28/20, at 2:15 p.m. RN-B verified speaking with [F-A] on 9/20/20, through the window and indicated performing a stroke assessment and everything seemed fine, that [R1] was just tired. RN-B verified [F-A] was demanding [R1] be sent to the ER. Regarding speaking with the on call physician RN-B verified not telling the physician the family wanted [R1] to be evaluated immediately. RN-B stated, "Since the vital signs were fine, I thought it would be better to find out what the labs and chest X-ray were before sending [R1] in." RN-B verified the on call physician was not informed that [R1] received blood transfusions 8/13/20 with anemia diagnosis.	F 580		

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F 580	Continued From page 7 Document review of the policy titled, Change in Resident Condition, dated 6/2019, read, The facility shall notify the resident/representative and physician health care provider of changes in the resident condition and/or status. 1. The licensed Nurse will notify the resident's physician/healthcare provider when there has been: A significant change in the resident's physical, emotional/mental condition, A need to alter the resident's medical treatment significantly; A need to transfer the resident to a hospital/treatment center. 2. Prior to notifying the physician/healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		10/20/20

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F 655	Continued From page 8 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a baseline individualized care plan to address a known diagnosis of anemia for 1 of 3 residents (R1) reviewed for individualized care plan. Findings include: R1's initial admission Minimum Data Set (MDS) dated 8/24/20, indicated R1 had moderate cognitive impairment, with diagnoses which included anemia, cerebral vascular accident (CVA) and malnutrition. R1's document review of interdisciplinary	F 655	Resident (R1) was discharged to the hospital and did not return to the facility. Audits were completed on all current residents to ensure care plans have been individualized to reflect residents problem areas, goals and interventions. Facility Policy, Change in Conditions, was reviewed and remains current. We will continue to develop a basic care plan within 48 hours of admission. We provide additional training to licensed nurses regarding appropriate care plan	

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F 655	Continued From page 9 progress notes (IPN) dated 8/13/20, at 11:22 a.m. indicated a lab value for a Hgb (iron-containing oxygen-transport metalloprotein in the red blood cells) of 6.1 grams per deciliter (normal value 13.8 to 17.2 g/dL) and the physician ordered R1 to be sent to the hospital for evaluation and blood transfusion. R1 was re-admitted back to the hospital 8/13/20, and returned to the facility on 8/17/20 with a Hgb of 8.2 g/dL post blood transfusions. R1's care plan review failed to address anemia with interventions or to address the low Hgb and recent blood transfusions or what the interventions would be specific for individualized care for R1 to watch for signs of internal bleeding. R1 was re-admitted back to the hospital on 9/21/20, with a Hgb of 4.7 g/dL for further blood transfusions. When interviewed on 9/28/20, at 10:55 a.m. nursing assistant (NA-A) stated, "[R1] needed encouragement to get up and get motivated, [R1] the last three days wasn't walking, the strength went down hill, [R1] was incontinent, would spill the urinal, [R1's] stools were dark, usually not that dark, I reported it to [RN-A] but was told that was iron deficiency, I reported the dark stools, nurses were aware of his stools, they said it was normal for [R1]." When interviewed on 9/28/20, at 1:32 p.m. the director of nursing (DON) verified anemia was not on the care plan and the facility expectation was to address the anemia on the care plan with interventions to observe for possible gastro intestinal bleeding with the drop in Hgb especially a darkening of the stool and extreme fatigue.	F 655	development, including necessary updates after readmission. An audit tool was developed to review 48 hour care plans to ensure they contain current problems, goals and interventions. Audits will be completed within 72 hours of admission by the DON or designee Audits will be conducted weekly for 6 weeks, every other week for 2 months and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. LNHA/designee is responsible	

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F 655	Continued From page 10 The policy titled Care Planning, dated, revision 6/2019, addressed a baseline care plan would be developed within 48 hours of admission and read, The interdisciplinary team will review the healthcare practitioner's orders and implement baseline care needs, including such things as; initial goals of the resident, physician orders, nursing orders,dietary orders, therapy services, and social services as needed." Furthermore the policy read, The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident.	F 655		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		11/4/20

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F 880	Continued From page 11 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure staff were wearing eye protection when providing direct care and/or in close contact for 5 of 7 residents (R8, R9, R10, R11, R13). Failed to ensure staff removed personal protective equipment (PPE) in a manner to prevent the potential spread of infection for 1 of 1 resident (R12) who required contact and droplet precautions. In addition, failed to ensure active screening and surveillance of staff for potential COVID-19 symptoms after entering the facility as recommended by Centers for Disease Control (CDC) and the State Health department guidelines. Findings include: On 9/28/20, at 7:19 a.m. during the entrance conference the director of nursing stated there were no resident or staff Covid 19 cases at the facility however the facility was admitting and re-admitting residents from the hospital and these residents were put on quarantine precautions and a negative Covid test result. -7:27 a.m. during the tour of the facility, registered nurse (RN)-E was observed standing right next to R11 in the room administering medications and her goggles were observed on top of her head. After RN-E completed the medication administration she walked out of R11's room. -At 7:28 a.m. surveyor came down the hallway to the nursing station where multiple staff were either being screened in or doing other duties	F 880	PERSONAL PROTECTIVE EQUIPMENT (PPE) Residents R8, R9, R10, R11, R13 have received cares with staff wearing proper PPE. R12 has received care with staff removing personal protective equipment (PPE) in a manner to prevent the potential spread of infection while on contact and droplet precautions. Staff have been educated to be wearing PPE for all cares and proper Donning and Doffing in the facility to include eye protection for non-COVID-19 residents. POLICIES/PROCEDURES/SYSTEM CHANGES: The Quality Assurance and Performance Improvement Committee conducted a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and developed intervention to prevent recurrence. The facility COVID policy was reviewed and is current to CDC and MDH current guidelines, specifically to: " policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.	

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F 880	Continued From page 13 however staff were not reminded to apply the goggles properly. -At 7:29 a.m. RN-E was observed to go into R9's room, still with her goggles on top of her head as she approached R9 then came out and returned to the medication cart by the nursing station. -At 7:35 a.m. the dietary aide (DA) was observed coming out of the kitchen, walked down the hallway past the nursing station, nurse manager office, and into the director of nursing (DON)'s office and was not wearing any eye protection at the time. At 7:37 a.m. DA was observed going down the hallway back to the kitchen past the nursing station where other staff stood, however DA was not reminded to apply eye protection. -At 7:39 a.m. a vendor driver was observed to enter the facility through the back door, then came down the short hallway and approached the nursing station. RN-C then approached the vendor driver and spoke to him as he handed a sheet of paper to RN-C. RN-C then stated to the vendor driver he was going to find the DON. RN-C left the nursing station area without screening the vendor driver. The vendor driver was observed to walk into the nursing station on the South hallway and then went into the bathroom by the nursing station and still had not been screened. -At 7:42 a.m. the vendor driver came out of the bathroom and was observed going back and forth between the bathroom and nursing station area and still had not been screened for Covid symptoms. -At 7:43 a.m. the DON approached the vendor driver and asked him to come to the desk to get screened by licensed practical nurse (LPN)-C and provided him a pair of goggles. -At 7:45 a.m. RN-E was observed coming out of R13's room still wearing her goggles on top of her	F 880	" policy and procedure for source control masks. " policies regarding standard and transmission based precautions and revise as needed. TRAINING/EDUCATION: The facility provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident□s rooms, whether it be for residents□ dietary needs or cleaning and maintenance services. The training will cover standard infection control practices, including, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. The training will include competency testing of staff and this must be documented. " Residents and their representatives will receive education on the facility□s Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident□s capacity. MONITORING/AUDITING: " The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions. " The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice	

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F 880	Continued From page 14 head after she had administered insulin, and then approached the medication cart. -At 7:49 a.m. to 7:51 a.m. RN-E was observed preparing R10's medications and at 7:54 a.m. RN-E carried the medications into R10's room still wearing the goggles on top of her head. RN-E then approached R10 who was up seated in the wheelchair and was observed standing approximately a half foot away as she administered the medications, without wearing eye protection. -At 8:25 a.m. two medical providers were observed entering the facility through the side door with their goggles on top of their heads. As they approached the surveyor approximately a distance of ten feet within the facility, both providers pulled the goggles to cover their eyes and walked down the South Transitional Care Unit (TCU) hallway past multiple resident rooms to the nursing station which was approximately two hundred feet before they were screened by RN-F. -At 8:29 a.m. RN-D was observed entering the facility and as she approached the nursing station she was observed reaching for a mask and applied the mask. RN-D then was observed going past the nursing station and the nurse manager office without being screened for Covid symptoms and was observed clocking in, then turned around and came back to the nursing station and was then was screened by RN-F. -At 10:35 a.m. licensed practical nurse (LPN)-B was screening another staff at the nursing station and was observed wearing regular reading glasses as her goggles were hanging on her chest. -At 10:42 a.m. LPN-B was observed to walk down the West hallway past a couple residents who were in the aviary room and then went and stood	F 880	weekly for one week once compliance is met. Audits will continue until 100% compliance is met on source control masking for staff, visitors and residents. " The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in use. " The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. and monitoring with the Quality Assurance Program Improvement (QAPI) program. POC ACTIVE SCREENING All staff have active screening and surveillance of staff for potential COVID-19 symptoms after entering the facility as recommended by Centers for Disease Control (CDC) and the State Health department guidelines. POLICIES/PROCEDURES/SYSTEM CHANGES: The Quality Assurance and Performance Improvement Committee conducted a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and developed intervention to prevent recurrence.	

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F 880	Continued From page 15 at the medication cart parked outside R14's room. -At 10:43 a.m. LPN-B still without proper eye protection, approached R8 to the right side. During the observation LPN-B stood right next to R8's wheelchair; no social distancing observed. On 9/28/20, at 9:38 a.m. RN-E was interviewed regarding the Covid screening process. RN-E stated all staff were supposed to enter through the back door and they were supposed to be symptom screened right away upon entry. RN-E stated, "we are supposed to have goggles and masks when we go into resident rooms or areas with residents, and if they are on precautions we're supposed to wear a gown. Right now we don't have anyone in this hallway." RN-E acknowledged not wearing eye protection when going in and out of residents rooms, and stated "they fog up all the time." On 9/28/20, at 10:53 a.m. the dietary aide acknowledged she did not have eyewear protection earlier because she had been in the kitchen and the goggles were fogging up so she had removed them and forgot to put them back on when she came out of the kitchen to the hallway where other residents and staff were. On 9/28/20, at 11:05 a.m. LPN-B was interviewed and explained that when she enters a resident room or in close contact to a resident she made sure to eye protection on, but at other times, like when at the nursing station, she did not because it was tight around the sides of her face. LPN-B acknowledged she should have had the eye protection on when standing right next to R8. On 9/28/20, at 11:06 a.m. RN-D explained being	F 880	The facility COVID policy was reviewed and is current to CDC and MDH current guidelines, regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy restrict entrance to anyone who does not meet the criteria as outlined by the CDC. The procedure includes actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. TRAINING/EDUCATION: The facility will provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training will cover the need for active screening. MONITORING/AUDITING: " The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

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worried about the mask and saw that there was a lot of commotion at the desk for screening, at the time, so decided to "clock in" and then return to the desk. RN-D stated, "I know I should have probably not done it."

On 9/28/20, at 11:08 a.m. an interview with the DON and the consultant corporate RN was completed. During the interview both the DON and corporate RN stated all staff were supposed to enter the building through the back door. The DON then stated, "we have been very strict to reinforce the eyewear because we were cited for it the last time an infection control survey was done here." The DON also explained that all staff were supposed to wear eyewear protection when providing cares to the residents, staff had been educated this and that audits had been completed. The corporate RN then stated "staff are to wear it if they are within the resident care area," and identified the care area, "is everywhere here." DON stated all staff and/or visitors were supposed to be screened upon entry to the facility at the nursing station and this was the expectation. The corporate RN explained which unit was previously a Covid unit and said that the doffing stations were outside the rooms in the hallway and this process was not changed when the unit was no longer a Covid unit; "we will re-educate the staff, we have systems but there are leaks, we have already started to educate the staff" and indicated the doffing stations were moved into the rooms. The DON commented on not being aware of who instructed staff to take PPE off outside residents rooms in the hallway.

The facility Coronavirus (COVID-19) policy dated 8/25/20, directed staff to adhere to appropriate infection control practices per recommendations

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of the Center for Disease Control (CDC) and the Department of health to prepare and minimize the exposure.

PPE removal:
During a continuous observation on 9/28/20, at 8:07 a.m. NA-A came out of R12's room wearing a gown, face mask, and eye protection, walked down the hallway approximately ten feet to the room prior to R12's and removed PPE in hallway and placed it in a bin.
-At 8:08 a.m. physical therapy assistant (PTA)-J came out of R12's room wearing a gown, face mask and eye protection, walked down the hallway to approximately ten feet to the room prior to R12's and removed PPE in the hallway and placed it in a bin.
-At 8:15 a.m. RN-C came out of R12's room wearing a gown, face mask, and eye protection, walked down the hallway to the room prior to R12's and removed the PPE in the hallway and placed it in a bin.
-At 8:31a.m. occupational therapy assistant (OTA)-K came out of R12's room wearing a gown, face mask, and eye protection, walked down the hallway between the wall and a cart where NA-A was passing breakfast trays to residents, to the room prior to R12's and removed the PPE in the hallway and placed it in a bin.
-At 8:59 a.m. NA-A came out of R12's room wearing a gown, face mask, and eye protection, placed a breakfast tray on top of the meal cart, walked down the hallway to the room prior to R12's and removed the PPE in the hallway and placed it in a bin.

During an interview on 9/28/20, at 9:18 a.m. RN-C indicated they were trying to have staff take PPE off in the room, but laundry had issues with

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F 880	Continued From page 18 removing the bins from the rooms. RN-C also explained that there were concerns about being contaminated if the PPE was removed while in the room and identified taking off the PPE in the room would not allow for social distancing of 6 feet from the resident During an interview on 9/28/20 at 9:40 a.m. NA-A indicated they were removing PPE in the hallway because they were told that they could be contaminated if they removed the PPE in the room.	F 880		

Electronically delivered
October 14, 2020

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: 6Y9S11

Dear Administrator:

The above facility was surveyed on September 28, 2020 through September 29, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT GREELEY LLC	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 September 28, & 29, 2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5342054C with a licensing order issued at 0265 and 1385. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		10/20/20

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2 265	Continued From page 2 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to report a significance of a change in condition for 1 of 3 residents (R1) reviewed for condition change of dark stool, increased weakness and new incontinence. The failure of the facility to inform the physician of a three day decline resulted in harm for R1 when hospitalized with a critical low hemoglobin (Hgb protein in red blood cells that carries oxygen from the lungs to the rest of the body) and required blood transfusions. Findings include: R1's initial admission Minimum Data Set (MDS) dated 8/24/20, indicated R1 had moderate cognitive impairment, with diagnoses which included anemia, cerebral vascular accident (CVA) and malnutrition. R1's document review of interdisciplinary progress notes (IPN) dated 8/13/20, at 11:22 a.m. indicated a lab value for a Hgb of 6.1 grams per deciliter (normal value 13.8 to 17.2 g/dL) and the physician ordered R1 to be sent to the hospital for evaluation and blood transfusion. R1 was admitted to the hospital and returned to the facility on 8/17/20 with a Hgb of 8.2 post blood transfusions. R1's IPN dated 9/14/20, read, "Continent of bowel and bladder for the most part, uses the urinal	2 265	corrected	

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2 265	Continued From page 3 independently." R1's IPN dated 9/20/20, at 1:08 p.m. registered nurse (RN-A) documented, "NAR [nursing assistant registered] reported to writer that resident is feeling weak." There was lack of follow up assessment or vital signs noted in chart. R1's IPN's dated 9/20/20, at 9:53 p.m. RN-B documented, "Pt informed family [F-A] who came to visit at the window that [R1] thought [R1] had a stroke earlier in the day, when Pt experienced weakness. Stroke assessment initiated per [F-A's] request, no S/sx [signs/symptoms] of stroke noted. Pt had elevated temp up to 102.0 temporal artery, temp was 98.3 orally and 98.5 auxiliary. Ice pack applied to forehead, will continue to monitor. Vs [vital signs] 114/60, 102.0, 20 68, 93 RA [room air]." RN-B did not document the stool color. R1's IPN's dated 9/21/20 at 1:14 a.m. read, Writer [RN-B] called the on call provider to report a change in condition and the on call ordered a chest X-ray and lab work. At 5:43 a.m. RN-B documented, "Pt's temp fluctuated all night, temp via temporal artery down to 100.0, orally 98.6. PRN [whenever necessary] Tylenol and cough syrup administered. Pt increased anxiety and restlessness noted, asking for ice chips and using cup of water for oral swabs for drinking. Pt also had urinal on mouth, writer intervened and removed it from mouth," The documentation did not address dark stools or a three day decline with new incontinence. R1's IPN dated 9/21/20, at 9:14 a.m. indicated the writer received a call from the lab that R1's Hgb was 4.7 g/dL which was reported to the physician who order R1 to be sent to the emergency room	2 265		

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2 265	Continued From page 4 via EMS (emergency medical services). R1 was admitted to the hospital on 9/21/20, with dx of critically low hemoglobin and required blood transfusions. When interviewed on 9/25/20, at 2:17 p.m. F-A stated on 9/20/20, at sometime between 8:30 - 9:00 p.m. through the window during an outside closed window visit, "I spoke with the nurse [RN-B] and told [RN-B] [R1] was worse, probably a stroke, why was the left eye drooping and they needed to send [R1] into the hospital, I asked the nurse to do a stroke assessment and find out why [R1] was so weak and this is a big change in condition. The nurse told me there was nothing to be concerned about and everything was fine. I told that nurse to send [R1] 911 to the hospital and they did not do it. We aren't allowed in the facility because of Covid but I knew there was a big change [R1] was too weak to even talk and the nurse did not listen when I said send [R1] 911 to the hospital. I left crying I was so upset that the nurse wouldn't listen to me, I could see something was very wrong. The hospital did tell me [R1] had another stroke and [R1] was bleeding internally, critical low of blood and needed transfusions and the nurse would not listen to me that something was very wrong. I was so upset" When interviewed on 9/28/20, at 10:55 a.m. nursing assistant (NA-A) stated, "[R1] needed encouragement to get up and get motivated, [R1] the last three days wasn't walking, the strength went down hill, [R1] was incontinent, would spill the urinal, [R1's] stools were dark, usually not that dark, I reported it to [RN-A] but was told that was iron deficiency, I reported the dark stools, nurses were aware of his stools, they said it was normal for [R1]."	2 265		

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2 265	Continued From page 5 When interviewed on 9/28/20, at 1:15 p.m. certified nurse practitioner (CNP) indicated [R1] was complex with a severe stroke in July, seen by neurology and on multiple anticoagulation at that time. The CNP indicated iron supplements could change the color of the stool but it would have been prudent for the nurse to report to the on call physician the fact that the nursing assistant thought there had been a deterioration for the past three days especially weakness, increased lethargy, incontinence and stool darkening in color. Furthermore, the CNP stated, "In light of the information from the nursing assistant pertaining to the change in bowel movement color and increased lethargy and change to incontinence, and the family insisting on an evaluation, it would have been prudent to inform the NP of those facts and I probably would have sent [R1] to the ER for evaluation right away." When interviewed on 9/28/20, at 1:24 p.m. RN-A verified [NA-A] reported that [R1] was weak and not feeling good, and being incontinent but did not recall if [NA-A] reported the stool was darker than usual. When interviewed on 9/28/20, at 1:32 p.m. the director of nursing (DON) verified now knowing that the NA-A reported 9/20/20, at 1:08 p.m. the change in [R1's] condition to the nurse should have prompted the nurse to evaluate the diagnosis of anemia and the Hgb of 6.1 g/dL in August which required hospitalization for blood transfusions would be information the on call physician should have been made aware of. Furthermore, the DON verified the family wishes to send to the ER due to stroke concerns should have been reported to the physician.	2 265		

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2 265	Continued From page 6 When interviewed on 9/28/20, at 1:57 p.m. physician for R1 verified importance to listen to the family concerns and as a team the information the nursing assistant shared was important for the on call physician to have been made aware of to help in determining the change in condition of a patient. When interviewed on 9/28/20, at 2:15 p.m. RN-B verified speaking with [F-A] on 9/20/20, through the window and indicated performing a stroke assessment and everything seemed fine, that [R1] was just tired. RN-B verified [F-A] was demanding [R1] be sent to the ER. Regarding speaking with the on call physician RN-B verified not telling the physician the family wanted [R1] to be evaluated immediately. RN-B stated, "Since the vital signs were fine, I thought it would be better to find out what the labs and chest X-ray were before sending [R1] in." RN-B verified the on call physician was not informed that [R1] received blood transfusions 8/13/20 with anemia diagnosis. Document review of the policy titled, Change in Resident Condition, dated 6/2019, read, The facility shall notify the resident/representative and physician health care provider of changes in the resident condition and/or status. 1. The licensed Nurse will notify the resident's physician/healthcare provider when there has been: A significant change in the resident's physical, emotional/mental condition, A need to alter the resident's medical treatment significantly; A need to transfer the resident to a hospital/treatment center. 2. Prior to notifying the physician/healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.	2 265		

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2 265	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility' policies regarding resident initial care plan information for anemia protocol diagnosis and interventions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 265		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure staff were wearing eye protection when providing direct care and/or in close contact for 5 of 7 residents (R8, R9, R10, R11, R13). Failed to ensure staff removed personal protective equipment (PPE) in a manner to prevent the potential spread of infection for 1 of 1 resident (R12) who required contact and droplet precautions. In addition, failed to ensure active screening and surveillance of staff for potential COVID-19 symptoms after entering the facility as recommended by Centers for Disease Control (CDC) and the State Health department guidelines.	21385	corrected	11/4/20

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21385	Continued From page 8 Findings include: On 9/28/20, at 7:19 a.m. during the entrance conference the director of nursing stated there were no resident or staff Covid 19 cases at the facility however the facility was admitting and re-admitting residents from the hospital and these residents were put on quarantine precautions and a negative Covid test result. -7:27 a.m. during the tour of the facility, registered nurse (RN)-E was observed standing right next to R11 in the room administering medications and her goggles were observed on top of her head. After RN-E completed the medication administration she walked out of R11's room. -At 7:28 a.m. surveyor came down the hallway to the nursing station where multiple staff were either being screened in or doing other duties however staff were not reminded to apply the goggles properly. -At 7:29 a.m. RN-E was observed to go into R9's room, still with her goggles on top of her head as she approached R9 then came out and returned to the medication cart by the nursing station. -At 7:35 a.m. the dietary aide (DA) was observed coming out of the kitchen, walked down the hallway past the nursing station, nurse manager office, and into the director of nursing (DON)'s office and was not wearing any eye protection at the time. At 7:37 a.m. DA was observed going down the hallway back to the kitchen past the nursing station where other staff stood, however DA was not reminded to apply eye protection. -At 7:39 a.m. a vendor driver was observed to enter the facility through the back door, then came down the short hallway and approached the nursing station. RN-C then approached the vendor driver and spoke to him as he handed a sheet of paper to RN-C. RN-C then stated to the	21385		

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21385	Continued From page 9	21385		

vendor driver he was going to find the DON. RN-C left the nursing station area without screening the vendor driver. The vendor driver was observed to walk into the nursing station on the South hallway and then went into the bathroom by the nursing station and still had not been screened.
-At 7:42 a.m. the vendor driver came out of the bathroom and was observed going back and forth between the bathroom and nursing station area and still had not been screened for Covid symptoms.
-At 7:43 a.m. the DON approached the vendor driver and asked him to come to the desk to get screened by licensed practical nurse (LPN)-C and provided him a pair of goggles.
-At 7:45 a.m. RN-E was observed coming out of R13's room still wearing her goggles on top of her head after she had administered insulin, and then approached the medication cart.
-At 7:49 a.m. to 7:51 a.m. RN-E was observed preparing R10's medications and at 7:54 a.m. RN-E carried the medications into R10's room still wearing the goggles on top of her head. RN-E then approached R10 who was up seated in the wheelchair and was observed standing approximately a half foot away as she administered the medications, without wearing eye protection.
-At 8:25 a.m. two medical providers were observed entering the facility through the side door with their goggles on top of their heads. As they approached the surveyor approximately a distance of ten feet within the facility, both providers pulled the goggles to cover their eyes and walked down the South Transitional Care Unit (TCU) hallway past multiple resident rooms to the nursing station which was approximately two hundred feet before they were screened by RN-F.

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21385	Continued From page 10 -At 8:29 a.m. RN-D was observed entering the facility and as she approached the nursing station she was observed reaching for a mask and applied the mask. RN-D then was observed going past the nursing station and the nurse manager office without being screened for Covid symptoms and was observed clocking in, then turned around and came back to the nursing station and was then was screened by RN-F. -At 10:35 a.m. licensed practical nurse (LPN)-B was screening another staff at the nursing station and was observed wearing regular reading glasses as her goggles were hanging on her chest. -At 10:42 a.m. LPN-B was observed to walk down the West hallway past a couple residents who were in the aviary room and then went and stood at the medication cart parked outside R14's room. -At 10:43 a.m. LPN-B still without proper eye protection, approached R8 to the right side. During the observation LPN-B stood right next to R8's wheelchair; no social distancing observed. On 9/28/20, at 9:38 a.m. RN-E was interviewed regarding the Covid screening process. RN-E stated all staff were supposed to enter through the back door and they were supposed to be symptom screened right away upon entry. RN-E stated, "we are supposed to have goggles and masks when we go into resident rooms or areas with residents, and if they are on precautions we're supposed to wear a gown. Right now we don't have anyone in this hallway." RN-E acknowledged not wearing eye protection when going in and out of residents rooms, and stated "they fog up all the time." On 9/28/20, at 10:53 a.m. the dietary aide acknowledged she did not have eyewear	21385		

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21385	Continued From page 11	21385		

protection earlier because she had been in the kitchen and the goggles were fogging up so she had removed them and forgot to put them back on when she came out of the kitchen to the hallway where other residents and staff were.

On 9/28/20, at 11:05 a.m. LPN-B was interviewed and explained that when she enters a resident room or in close contact to a resident she made sure to eye protection on, but at other times, like when at the nursing station, she did not because it was tight around the sides of her face. LPN-B acknowledged she should have had the eye protection on when standing right next to R8.

On 9/28/20, at 11:06 a.m. RN-D explained being worried about the mask and saw that there was a lot of commotion at the desk for screening, at the time, so decided to "clock in" and then return to the desk. RN-D stated, "I know I should have probably not done it."

On 9/28/20, at 11:08 a.m. an interview with the DON and the consultant corporate RN was completed. During the interview both the DON and corporate RN stated all staff were supposed to enter the building through the back door. The DON then stated, "we have been very strict to reinforce the eyewear because we were cited for it the last time an infection control survey was done here." The DON also explained that all staff were supposed to wear eyewear protection when providing cares to the residents, staff had been educated this and that audits had been completed. The corporate RN then stated "staff are to wear it if they are within the resident care area," and identified the care area, "is everywhere here." DON stated all staff and/or visitors were supposed to be screened upon entry to the facility at the nursing station and this was the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT GREELEY LLC	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 12	21385		

expectation. The corporate RN explained which unit was previously a Covid unit and said that the doffing stations were outside the rooms in the hallway and this process was not changed when the unit was no longer a Covid unit; "we will re-educate the staff, we have systems but there are leaks, we have already started to educate the staff" and indicated the doffing stations were moved into the rooms. The DON commented on not being aware of who instructed staff to take PPE off outside residents rooms in the hallway.

The facility Coronavirus (COVID-19) policy dated 8/25/20, directed staff to adhere to appropriate infection control practices per recommendations of the Center for Disease Control (CDC) and the Department of health to prepare and minimize the exposure.

PPE removal:
During a continuous observation on 9/28/20, at 8:07 a.m. NA-A came out of R12's room wearing a gown, face mask, and eye protection, walked down the hallway approximately ten feet to the room prior to R12's and removed PPE in hallway and placed it in a bin.
-At 8:08 a.m. physical therapy assistant (PTA)-J came out of R12's room wearing a gown, face mask and eye protection, walked down the hallway to approximately ten feet to the room prior to R12's and removed PPE in the hallway and placed it in a bin.
-At 8:15 a.m. RN-C came out of R12's room wearing a gown, face mask, and eye protection, walked down the hallway to the room prior to R12's and removed the PPE in the hallway and placed it in a bin.
-At 8:31a.m. occupational therapy assistant (OTA)-K came out of R12's room wearing a gown, face mask, and eye protection, walked

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21385	Continued From page 13 down the hallway between the wall and a cart where NA-A was passing breakfast trays to residents, to the room prior to R12's and removed the PPE in the hallway and placed it in a bin. -At 8:59 a.m. NA-A came out of R12's room wearing a gown, face mask, and eye protection, placed a breakfast tray on top of the meal cart, walked down the hallway to the room prior to R12's and removed the PPE in the hallway and placed it in a bin. During an interview on 9/28/20, at 9:18 a.m. RN-C indicated they were trying to have staff take PPE off in the room, but laundry had issues with removing the bins from the rooms. RN-C also explained that there were concerns about being contaminated if the PPE was removed while in the room and identified taking off the PPE in the room would not allow for social distancing of 6 feet from the resident During an interview on 9/28/20 at 9:40 a.m. NA-A indicated they were removing PPE in the hallway because they were told that they could be contaminated if they removed the PPE in the room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility' policies regarding infection control practices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21385		

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- 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.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.
and monitoring with the Quality Assurance Program Improvement (QAPI) program.

ACTIVE SCREENING

- 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.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.