Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 29, 2025

Administrator
Capitol View Transitional Care Center
640 Jackson Street
Saint Paul, MN 55101

RE: CCN: 245534
Cycle Start Date: December 5, 2024

Dear Administrator:

On January 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

Administrator
Capitol View Transitional Care Center
640 Jackson Street
Saint Paul, MN 55101

RE: CCN: 245534
Cycle Start Date: December 5, 2024

Dear Administrator:

On December 5, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 5, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	245534	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

(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 On 12/2/24, through 12/5/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a 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 that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/2/24, through 12/5/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55341520C (MN00101572). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/20/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	C 12/05/2024

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CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 1 of 1 resident (R171) observed with medications at the bedside. Findings include: R171's Entry Tracking Record dated 11/25/24, indicated R171 was admitted to the facility on 11/25/24. R171's face sheet dated 12/4/24 at 11:23 a.m., indicated the following diagnoses: reactive airway disease, closed fracture of the right humerus (upper arm), closed left hand fracture, osteoporosis (a disease that weakens bones) with pathological fracture (a fracture due to underlying disease), closed nondisplaced fracture of first metacarpal (bone near the thumb) bone of the left hand, closed displaced (out of alignment) fracture of shaft of first metacarpal bone of left hand. R171's temporary care plan (TCP) dated 11/25/24, indicated intact cognition. Additionally, the TCP indicated on 12/4/24, R171 could SAM inhalers at the bedside.	F 554	Patient identified as R171 has discharged. An self-administration of mediation was completed on 12/4/24 to support the patients wishes and ability to keep the inhaler by bedside. Care plan was updated to reflect this change. The nurse that cared for the patient on 12/3/24 that left the inhaler by bedside has been disciplined/ re-educated on all steps needed for self-administration of medication: nurse assessment, IDT assessment, physician order and SAM plan of care. All nurses will be re-educated on the requirements of F554; specifically the nursing staff on the importance of completing the self-administration assessment if applicable before any resident self-administers medication, this includes leaving medications at bedside for residents to take at a later time. The DON or designee will monitor all new admissions for self-administration assessment completion if appropriate. An environmental rounding tool was implemented, it includes checking the resident's rooms for any medications that should be secured. DON or designee will conduct this audit at random weekly x 3, then bi-weekly x 2, and then monthly x 1.	12/31/24

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	245534	A. BUILDING _____ B. WING _____	C 12/05/2024

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F 554	Continued From page 2 R171's physician's orders indicated the following orders: 11/25/24, fluticasone-vilanterol (Breo Ellipta) 100-25 MCG (microgram)/ACT (actuation) inhaler 1 dose daily. 11/25/24, umeclidinium (Incruse Ellipta) 62.5 MCG/ACT inhaler 1 puff daily. R171's physician's orders lacked information R171 could self administer inhalers. R171's admission progress note dated 11/25/24 at 3:09 p.m., indicated R171 was unable to use arms to eat, was non-weight bearing on the left wrist and had a sling to the right shoulder. R171's SAM dated 12/4/24, indicated R171 wished to self administer medications and was appropriate for R171 to self-administer the Incruse Ellipta and Breo Ellipta and medications would be stored at the bedside. During interview and observation on 12/3/24 at 8:51 a.m., and 9:02 a.m., registered nurse (RN)-A picked up the Incruse Ellipta inhaler 62.5 mcg/ACT and was looking for the Breo Ellipta that was located on R171's bedside table. RN-A provided R171 with the Breo Ellipta inhaler and some water. RN-A stated she had to check to see if R171 could have the Breo Ellipta at the bedside and stated staff looked in the summary and the medication administration record (MAR) to know if a resident could self administer their medication. RN-A viewed the computer and stated there was nothing located in the medical record that indicated R171 could self administer the medication and stated she would put the medication back in the drawer. Further, RN-A stated an assessment was completed on admission to determine whether a resident could	F 554	All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F 554	Continued From page 3 self administer a medication. During interview on 12/4/24 at 9:40 a.m., the director of nursing (DON) stated the nurse asks residents whether they would like to keep any medications at the bedside and stated the assessment is completed and placed in an orange book at the nursing stations and then a tag line located at the top of the electronic medical record (EMR) is placed if a resident can SAM. The DON reviewed R171's record and stated she did not locate anything and stated she did not recall R171 having a SAM and stated if they don't want to SAM, medications were not left at the bedside until they were reassessed. A policy, Self-Administration of Drugs, dated September 2024, indicated patients who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. As part of their overall evaluation, the staff and practitioner will assess each patient's mental and physical abilities, to determine whether a patient is capable of self-administering medications. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including ability to read and understand medication labels, comprehension of the purpose and proper dosage and administration time for his or her medications, ability to remove medications from a container and to ingest and swallow them, and ability to recognize risks and major adverse consequences of his or her medications. If the staff or IDT determines that a patient cannot safely self-administer medications, the nursing staff will administer the patient's medications.	F 554		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING _____ B. WING _____	C 12/05/2024

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CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

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F 761	Continued From page 4 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that an opened medication was labeled and contained the correct expiration date for one of one resident (R126), and failed to ensure an expiration date was documented on an opened medication for one of one resident (R176) reviewed. Further, staff were not aware of the correct expiration date of an insulin medication once opened.	F 761	Patient identified as R126 and F176 have discharged. Capitol View will assure all multi-does vials sent by admitting hospital will have proper labeling for administration at Capitol View or storage at Capitol View for utilization at home. Nursing staff will be reeducated on medication parameters and proper procedure for labeling muli-dose mediation. DON/designee will audit the	

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F 761	Continued From page 5 Findings include: The Admelog website, products.sanofi.us/admelog/admelog.pdf indicated opened Admelog insulin vials must be used within 28 days or be discarded, even if they still contained Admelog. R126: R126's face sheet form dated 12/4/24 at 11:32 a.m., indicated R126 had a diagnosis of type two diabetes. R126's physician's orders form indicated the following order: 11/25/24, insulin lispro (Humalog, Admelog) injection vial, inject 10 units three times a day with meals. During interview and observation on 12/3/24 between 8:10 a.m., and 8:45 a.m., registered nurse (RN)-B pulled a multi-dose vial of Admelog insulin 100 units/milliliter (ML) out of the medication cart. The insulin did not contain a label that identified who the insulin belonged to. Further, the insulin was not in a bag. RN-B stated at 8:29 a.m., the insulin was not labeled, but stated she knew it was R126's insulin because R126 was there the day prior and stated she could go into the refrigerator and waste the bottle, however stated there was none in the refrigerator. At 8:43 a.m., RN-B opened a new multi-dose vial of Admelog insulin and stated she assumed the insulin expired after one month and added an expiration date of 1/3/25, and administered the insulin to R126 at 8:45 a.m. During interview on 12/3/24 at 12:34 p.m., RN-D	F 761	pyxis systems randomly weekly x 3, then bi-weekly x 2, and then monthly x 1. DON/designee will be responsible for compliance. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

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F 761	Continued From page 6 stated all insulins were discarded 28 days after opening. During interview on 12/4/24 at 11:24 a.m., the pharmacist consultant (PC) stated insulin bottles stored in drawers with multiple residents should contain identifiable information on who the insulin belonged to. R176: R176's face sheet form dated 12/4/24 at 11:15 a.m., indicated R176 had type two diabetes mellitus without complication, with long-term current use of insulin. R176's physician's orders form indicated the following order: 11/27/24, insulin lispro (Humalog, Admelog) injection vial 4 units three times a day with meals. During interview and observation on 12/5/24 between 10:19 a.m., and 10:29 a.m., licensed practical nurse (LPN)-A explained the process of dispensing medications from the Pyxis medication cart. LPN-A stated when administering medications, opens the chart and reviews medications. LPN-A stated all insulin bottles were multi-use vials and were dated when opened, and expired after 30 days. Further, LPN-A verified R176 had a multi-dose vial of Admelog that was opened on 12/2/24, but did not contain an expiration on the bottle. During interview on 12/5/24 at 10:56 a.m., LPN-A stated she clarified the expiration date for Admelog was actually 28 days with RN-D. During interview on 12/4/24 at 9:40 a.m., the	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	640 JACKSON STREET SAINT PAUL, MN 55101

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F 761	Continued From page 7 director of nursing (DON) stated their policy indicated insulins were labeled with the patient name and date of birth, physician, and medical record number and were dated when opened and further, the vial was scanned and the order showed up for staff to be certain they had the correct medication. The DON stated it was important to have a label in order to know who the medication belonged to. During interview on 12/5/24 at 11:01 a.m., the DON stated they were looking at the open date and have not always written the expiration date but the rule was 28 days. A policy, Labeling of Medication Containers, dated September 2024, indicated all medications maintained in the facility shall be properly labeled in accordance with current state and Federal regulations. Labels for individual drug containers shall include all necessary information such as the expiration date when applicable. Further, labels for small multi-dose containers will include all necessary information: the patient's name, the patient's MRN (medical record number), attending physician, and the date opened.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245534	A. BUILDING **02 - CAPITAL VIEW TRANSITIONAL CARE UNIT** B. WING _____	**12/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW TRANSITIONAL CARE CENTER	**640 JACKSON STREET** **SAINT PAUL, MN 55101**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 3, 2024, 2018. At the time of this survey, Capitol View Transitional Care Center, was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building Information This 10-story building was constructed in 1965, and was determined to be of Type I(332) construction. The building has a full basement and is fully fire sprinklered. The building has a fire alarm system, with smoke detection in spaces open to the corridor and in all resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 31 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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.