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	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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 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 [DATE]. 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. 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. (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 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. 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 [DATE] at 11:32 a.m., indicated R126 had a diagnosis of type two diabetes. R126's physician's orders form indicated the following order: [DATE], insulin lispro (Humalog, Admelog) injection vial, inject 10 units three times a day with meals. During interview and observation on [DATE] 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 [DATE], and administered the insulin to R126 at 8:45 a.m. During interview on [DATE] at 12:34 p.m., RN-D stated all insulins were discarded 28 days after opening. During interview on [DATE] 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 [DATE] at 11:15 a.m., indicated R176 had type two diabetes mellitus without complication, with long-term current use of insulin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R176's physician's orders form indicated the following order: [DATE], insulin lispro (Humalog, Admelog) injection vial 4 units three times a day with meals. During interview and observation on [DATE] 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 [DATE], but did not contain an expiration on the bottle. During interview on [DATE] 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 [DATE] at 9:40 a.m., the 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 [DATE] 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 [DATE], 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.