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	11/19/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review the facility failed to ensure a skin tear had continued monitoring and treatment for 1 of 1 resident (R17) reviewed for non-pressure skin injuries. Findings include: R17's face sheet dated 11/12/25, indicated R17 was recently admitted to the facility and had diagnoses of pathological compression fractures of the cervical spine and squamous cell cancer involving the bone.R17's Wound Care Alert dated 11/12/25, indicated R17 had a skin tear on the right forearm that was covered with a mepelix (foam protective dressing). The document lacked indication of an assessment or description of the skin tear. R17's daily skin assessments dated 11/12/25- 1/17/25, indicated R17 had a skin tear, however lacked where it was located or if further monitoring or treatments were provided.R17's provider and nursing orders as of 11/17/25, lacked indication of treatment orders for R17's skin tear.A facility document titled Standing Orders dated 2/2025, directed staff to cleanse minor skin tears, and cover with non-adherent dressing. Furthermore, the standing orders directed staff to change all dressings every three days and as needed. R17's temporary care plan dated 11/12/25, lacked indication R17 had a current skin tear or was at risk for skin injury. During observation and interview on 11/17/25 at 1:00 p.m., R17 was sitting in their wheelchair in her room. R17 had a mepelix (foam dressing used to protect the skin) on her right forearm, dressing was undated. R17 was not sure what was underneath the mepelix and couldn't remember when it was placed. R17 further stated she gets bruises and bumps all the time. An observation on 11/18/25 at 8:35 a.m., nursing assistant (NA)-A was assisting R17 to the bathroom. An undated mepelix was still in place on R17's forearm. When interviewed on 11/18/25 at 2:11 p.m., registered nurse (RN)-A stated when a skin alteration was found on a resident, an assessment of it would be completed. The assessment included what the skin altercation was, measurements and what was done. The skin alteration would then be placed on the body avatar in the residents electronic medical record (EMR). RN-A verified the undated mepelix on R17's forearm and believed it was a skin tear that happened prior to admission and had not provided any cares or looked under the mepelex dressing. RN-A verified R17's body audit did not indicate there was a skin alteration on R17's forearm and a Lines, Drains, Airway (LDA) (specific flowsheet documentation where skin alterations and wounds documented) had not been created for R17's arm. Furthermore, RN-A was not able to find a progress note to indicate when the mepelix was placed or if it had been changed.A follow up interview at on 11/18/25 at 2:24 p.m., RN-A stated they had removed R17's mepelix dressing and it appeared to be a skin tear. RN-A stated the skin tear was almost completely healed and now believed the dressing was placed at the facility and not prior to admission. When interviewed on 11/18/25 at 2:43 p.m., the Director of Nursing (DON) stated upon admission, any skin altercation would be expected to be documented on the body audit. If the staff find a new wound or skin injury, the nurse will add to the body audit and add an LDA to complete the assessment. If there was a need for a dressing, the nurse would obtain one. DON further stated nurses are trained to peel back a mepelix to determine what the skin injury is and what is going on with it. When interviewed on 11/18/25 at 3:43 p.m., RN-B stated only major wounds were added for an LDA. RN-B stated documentation from the paper form of the body audit done upon admission was found and it was noted to be a skin tear and the mepelix was placed by the facility upon admission. RN-B stated the skin tear was not placed in (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's body audit that was in the EMR and the paper form was for the MDS nurse to review. RN-B verified there was there was no further assessment or description of the skin tear in R17's medical record.A follow up interview on 11/19/25 at 11:06 a.m., DON stated with evening admissions, RN-B was usually emailed with any resident skin injuries to add an LDA, and ensure documentation was completed, however there wasn't an email sent. DON expected staff to follow this process to ensure an LDA was placed to monitor the skin tear and indicate if treatment was provided. A facility policy titled Wound Care dated 12/10/24, directed staff to dress minor skin variations with a non-adherent dressing. Furthermore, staff were directed to record the type of wound care provided and all assessment data obtained when inspecting the wound on a flow sheet or progress note.